

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13916

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13803		First <i>Louis</i>	Middle <i>Aaron</i>	Last <i>-</i>	20. DATE OF DEATH Month <i>10</i> Day <i>68</i> Year <i>1968</i>	2b. HOUR <i>10:50AM</i>
1. DECEASED NAME (Type or print)	3. SEX <i>Male</i>	4. RACE <i>White</i>	S. DATE OF BIRTH <i>9/9/85</i>	6. AGE (In years last birthday) <i>83</i> YRS.	IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS. MONTHS <i>0</i> DAYS <i>0</i> HOURS <i>0</i> MIN. <i>0</i>
7a. BIRTHPLACE (State or foreign country) <i>Balto</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Baltimore</i>			
10. CITY OR TOWN OF DEATH <i>Baltimore</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Baltimore County General</i>		12o. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Ret. Conductor</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Balto. Trans</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>	13b. COUNTY <i>Balto.</i>	13c. CITY OR TOWN <i>Balto</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>3504 Ellen Road</i>		
14. FATHER'S NAME First <i>James Aaron</i>	Middle <i></i>	Last <i></i>	15. MOTHER'S MAIDEN NAME First <i>Jessie Courts</i>	Middle <i></i>	Last <i></i>	
16o. WAS DECEASED EVER IN U.S. ARMED FORCES? NO, no, or unknown)	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT <i>Mr. Henry H. Aaron</i>	Address <i>3504 Ellen Road 21207</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))						
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF <i>acute myocardial infarction</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 hrs.</i>						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i></i> DUE TO, OR AS A CONSEQUENCE OF <i>ASCV.D.</i> <i>6 yrs.</i>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)						
19a. DATE OF OPERATION <i>1/20/68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i></i>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i></i>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i></i>			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <i></i>	21f. LOCATION Street or R.F.D. No. <i></i>	City or Town <i></i>	County <i></i>	State <i></i>
22a. I certify that (I) (this hospital) attended the deceased from <i>1961</i> , to <i>10/14/68</i> , that (I) (we) last saw the deceased alive on <i>10/14/68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.						
22b. SIGNATURE <i>M. J. Ellin M.D.</i>		DEGREE ATTENDING PHYS. <i></i>	MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>10/14/68</i>		
22d. PHYSICIAN'S NAME (Type) <i>M. J. Ellin</i>		22e. ADDRESS <i>8629 Liberty Rd - Randallstown</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>Oct. 17, 68</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Loudon Park Cemetery</i>	23d. LOCATION (City or Town) <i>Frederick Ave. Balto Md.</i>	(County) <i></i>	(State) <i></i>	
24. FUNERAL DIRECTOR <i>Loring Byers</i>	ADDRESS <i>8728 Liberty Rd. Randallstown Md.</i>		25a. RECD BY REGISTRAR <i>OCT 16 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

81081

60381

45

6581.01 130

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death is necessary, please execute the certificate, writing the word "pending" in pencil in Item 8. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

13306

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13917

1. DECEASED NAME (Type or Print)	First JAMES	Middle JOSEPH	Last ALLUM	2a. DATE KNOWN OF ESTI- MATED <input checked="" type="checkbox"/>	Month OCT. 13,	Day Year 1968	2b. HOUR a.m. 10:45
3. SEX MALE	4. RACE WHITE	S. DATE OF BIRTH 11/20/92	6. AGE (In years last birthday) 75	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN. 0
7a. BIRTHPLACE (State or foreign country) IRELAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE,	2c. DATE PRONOUNCED DEAD Month OCTOBER			
10. CITY OR TOWN OF DEATH FORT HOWARD	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VETERANS ADMIN. HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) PAINTER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission). STATE MARYLAND	13b. COUNTY —	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 140 E. CLEMENT STREET			
14. FATHER'S NAME WILLIAM	First —	Middle —	Last ALLUM	15. MOTHER'S MAIDEN NAME ELIZABETH	First —	Middle —	Last McKNIGHT
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES	16b. SOCIAL SECURITY NO. (If yes, enter year or dates of service) WWI 212 12 45 44	17. INFORMANT CLINICAL RECORDS, VAH, FT. HOWARD, MD.	ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Thick cerebral Hematoma - left</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Frontal Paroxysmal</i> last <i>9000</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Alcohol</i> — DUE TO, OR AS A CONSEQUENCE OF (c) <i>Alcohol</i> — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mos							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Alcohol</i> —							
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION 8-26-68	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Alone	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH AT HOME	21b. TIME OF INJURY Month, Day, Year HOUR A.M. PM	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Fell down stairs struck head					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) AT HOME	21f. LOCATION Street or R.F.D. No. 140 E. CLEMENT ST., BALTO.	City or Town 30	County MD.	State		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>M. B. Davis</i>	22b. CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (City, town, or county) 140 E. FORT AVE., BALTO., MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 10/17/68	23c. NAME OF CEMETERY OR CREMATORIAL HOLY CROSS CEMETERY	23d. LOCATION (City or Town) BALTIMORE,	(County) MD.			
24. FUNERAL DIRECTOR JAMES J. McCULLY FUNERAL DIR., BALTO., MD.	ADDRESS 130 E. FORT AVE., BALTO., MD.	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE				

TIGER

LOCK

1000

WELFARE

TRUST

RELIEF

1000 BOSTON

1000 NEW YORK

1000

TRUST

1000

CHARITY

1000

1000 NEW YORK

1000

1000 NEW YORK

1000 NEW YORK

1000

TRUST

1000

WELFARE

1000

1000 NEW YORK

1000

1000

1000 NEW YORK

1000

1000 NEW YORK

1000 NEW YORK

1000

1000 NEW YORK

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

13907

13918

1. DECEASED-NAME (Type or Print)				First	Middle	Lost	2a. DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b. HOUR
RICHARD F. W. ALTE							<input checked="" type="checkbox"/>	Oct.	11	1968	AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH 6/5/1878	6. AGE (in years at birthday) 90	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Oct. 11, 1968	Day	Year 19	2d. HOUR 12:30 P.M.	
7. BIRTHPLACE (State or foreign country) Germany		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore					
10. CITY OR TOWN OF DEATH Essex 21221		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 70 Silver Lane		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Store-keeper		12b. KIND OF BUSINESS OR INDUSTRY Store					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Baltimore	13c. CITY OR TOWN Essex	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 70 Silver Lane							
14. FATHER'S NAME Unknown	First	Middle	Lost	15. MOTHER'S MAIDEN NAME Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. 214 22 6996		17. INFORMANT William Metzger 726 S. Marilyn Ave. 21221		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4369		DUE TO, OR AS A CONSEQUENCE OF (b) Acute Cerebral Vas accident		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 331 X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. Dundalk, Md. 21222		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Theodore Patterson</i>		EXAMINER'S NAME (Theodore Patterson, M. D. 105 Main St. Dundalk, Md. 21222)		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, BURIAL (Specify) Burial		23b. DATE 10/14/68		23c. NAME OF CEMETERY OR CREMATORIAL Oak Lawn Cemetery		23d. LOCATION (City or Town) Baltimore, Md.		(County)		(State)	
24. FUNERAL DIRECTOR <i>Bruzdzinski</i>		ADDRESS Bruzdzinski Funeral Home 1407 Eastern Ave.		25a. RECD BY REGISTRAR DATE OCT 14 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in box 4. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm S may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13903

13919

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and ~~entirely~~ filled in, ~~remove~~ the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First MARJORIE S. ANDERSON	Middle S.	Last ANDERSON	20. DATE OF DEATH Month 10 Day 12 Year 68	2b. HOUR 6:40 A.M.				
3. SEX Female	4. RACE Negro	5. DATE OF BIRTH 5.12.1916		6. AGE (in years lost birthday) 52 yrs.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County,					
10. CITY OR TOWN OF DEATH Mount Wilson	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mt. Wilson St. Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 909 HARLEM Ave.						
14. FATHER'S NAME First CHARLES F. REID	Middle 	Last 	15. MOTHER'S MAIDEN NAME First EMMA J. HALL	Middle 	Last 				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 220-18-6908	17. INFORMANT Records, Mt. Wilson State Hospital	Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PAR-ADVANCED AUTO NALY 011.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, last.						2 SUBSEQUENT, ISOLATOR			
(b) _____ DUE TO, OR AS A CONSEQUENCE OF									
(c) _____ DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
0001		19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
MEDICAL CERTIFICATION		21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
/		21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
/		22a. I certify that (I) (this hospital) attended the deceased from 10.7.1968 , to 10.12.1968 , that (I) (we) last saw the deceased alive on 10.12.1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
/		22b. SIGNATURE William Newcomer			DEGREE	ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input checked="" type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 10.12.1968
/		22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D.			22e. ADDRESS Mount Wilson, Maryland				
/		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Oct. 16, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Arbutus Mem. Park	23d. LOCATION (City or Town) Baltimore, Md.	(County) Baltimore	(State) Md.		
/		24. FUNERAL DIRECTOR Charles R. Law	ADDRESS 802 Madison Ave.	25a. REC'D BY REGISTRAR DATE OCT 17 1968	25b. REGISTRAR'S SIGNATURE Charles Judge				
/		30M REV. 1/64							

91051

100% of the time

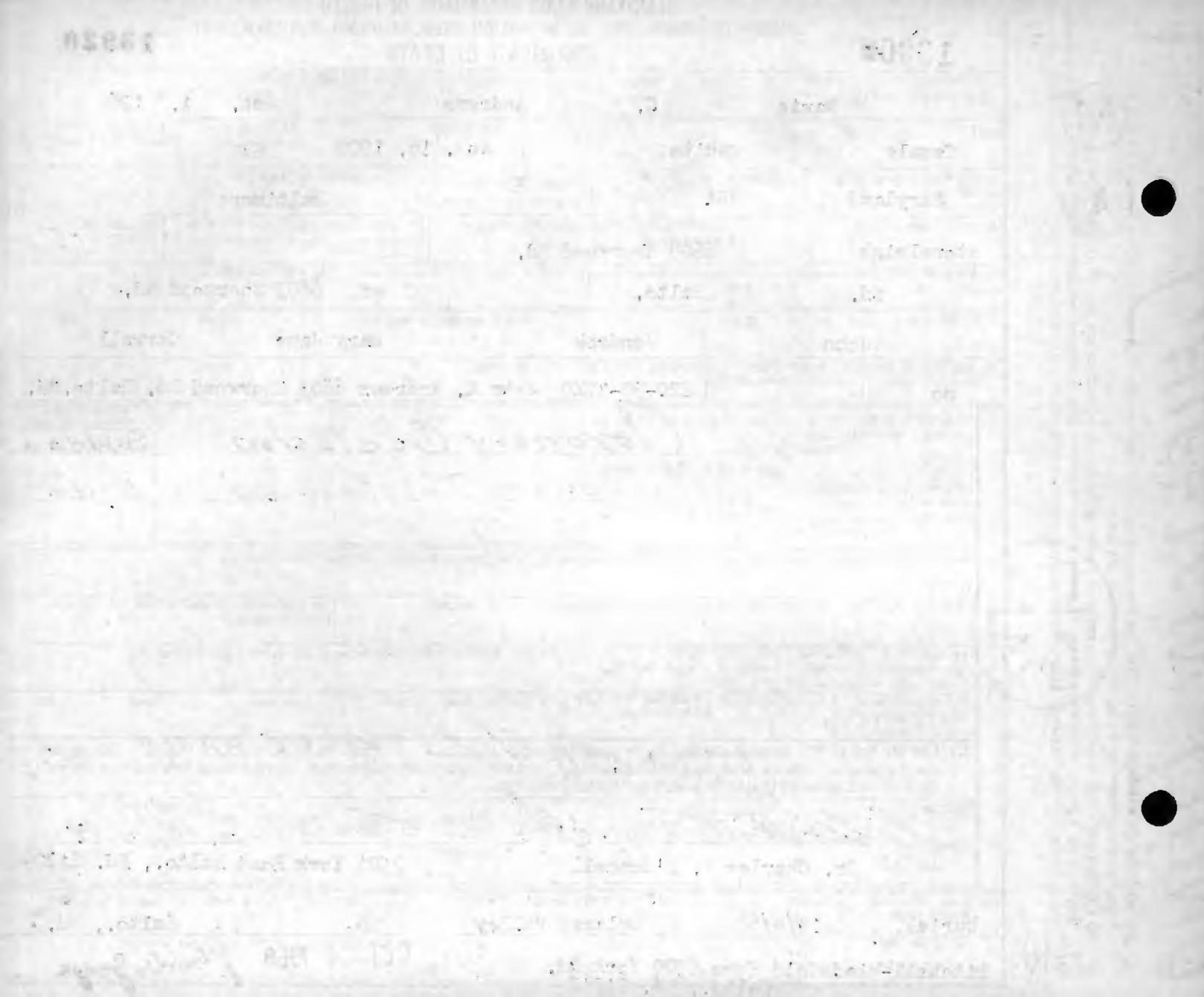
the same time

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

13920

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 4 may be retained by the hospital or attending physician. This certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)		First Marie	Middle C.	Last Andrews	2a. DATE OF DEATH Month Oct.	Day 1	Year 1968	2b. HOUR M
3. SEX female		4. RACE white		S. DATE OF BIRTH Aug. 18, 1900	6. AGE (In years last birthday) 68		IF UNDER 1 YEAR MONTHS YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
10. CITY OR TOWN OF DEATH Stoneleigh		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 6603 Sherwood Rd.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 6603 Sherwood Rd.		
14. FATHER'S NAME First John		Middle Jendrek	Last	15. MOTHER'S MAIDEN NAME First Mary Jane	Middle	Last Carroll		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 220-30-4720		17. INFORMANT John Q. Andrews 6603 Sherwood Rd. Balto. Md.		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109		OUE TO, OR AS A CONSEQUENCE OF (b) Coronary Occlusion		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last,		OUE TO, OR AS A CONSEQUENCE OF (c) Coronary Insufficiency		5 yrs				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from September 1968 , to October 1968 , that (I) (we) last saw the deceased alive on September 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Charles F. O'Donnell		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 10/3/68			
22d. PHYSICIAN'S NAME (Type) Dr. Charles F. O'Donnell		22e. ADDRESS 7501 York Road Balto., Md. 21204						
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 10/4/68	23c. NAME OF CEMETERY OR CREMATORIAL Dulaney Valley		23d. LOCATION (City or Town) Balto., Md.		(County)	(State)
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home 6500 York Rd. Balto., Md. 21212		ADDRESS		25a. REC'D BY REGISTRAR DATE OCT 4 1968	25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3 Page 5 may be retained for your files.

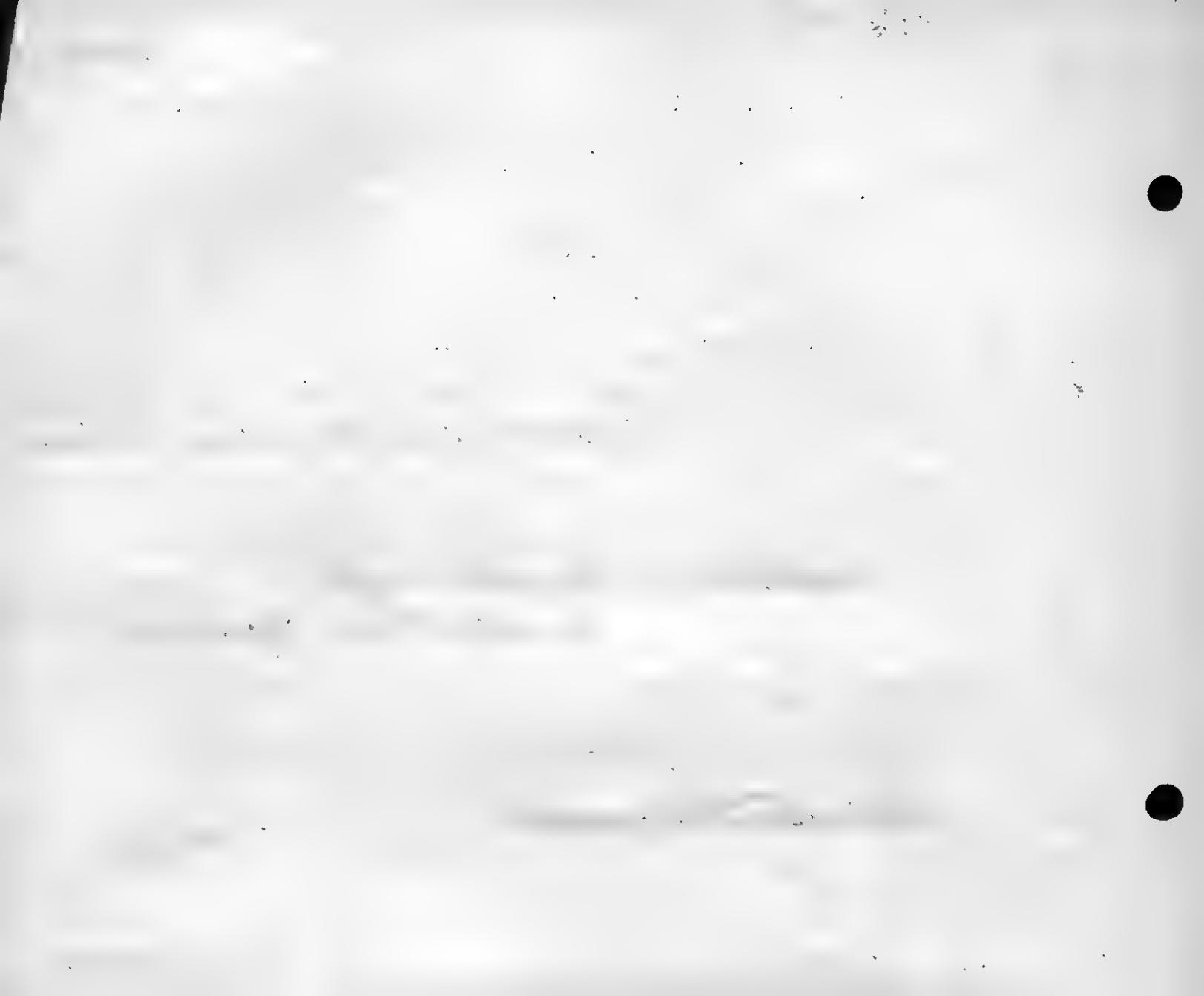
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13921

1 DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MADE	Month	Day	Year	2b. HOUR
MELVIN F. BACK						Oct. 23	168			M
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	F UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month	Day	Year	2d. HOUR	
male	white	2/4/1900	68 YRS			Oct	23	1968	M	
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH							
Maryland	USA	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Baltimore County							
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY							
Towson	St. Joseph's		Western Elec							
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e STREET AND NUMBER							
Maryland	Balto.	Parkville	YES <input type="checkbox"/> NO <input type="checkbox"/> 2512 Taylor Avenue							
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last			
Adam John Back				Elizabeth Schmidt						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS							
no	215 10 4033	family records								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF <i>Coronary Occlusion Sudden</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF lost (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Insertion of Prosthetic Hip</i>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?				
						Crushed Hip of 20 year duration				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury, Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								22b. DATE SIGNED <i>Charles D. Howell</i>		
ACTUAL SIGNATURE <i>Charles D. Howell</i> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type)								DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
burial		Oct 26 '68	Parkwood			Parkville, Balto Md.				
24. FUNERAL DIRECTOR		ADDRESS			25a. RECD BY REGISTRAR	25b. REGISTRAR'S SIGNATURE				
C. F. EVANS & SON 8802 Harford Rd.					OCT 28 1968	Charles Judge				



13911

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

13922

I. DECEASED NAME (Type or print)	First ETHEL I BAKER	Middle 	Last 	2a. DATE OF DEATH Month Oct. Day 27 Year 1968	2b. HOUR 7 A.M.
3. SEX F	4. RACE W	S. DATE OF BIRTH July 21 1902	6. AGE (in years last birthday) 66	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Baltimore	Md.	
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Chesapeake Manor	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY Uniforms	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Balto	13c. CITY OR TOWN Parkville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 2901 Linganore ave.	
14. FATHER'S NAME First James H. Wilson	Middle 	Last 	15. MOTHER'S MAIDEN NAME First Catherine R. Miller	Middle 	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Or unknown No	16b. SOCIAL SECURITY NO. 212-26-6201	17. INFORMANT Family records	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of lung generalized</i> DUE TO, OR AS A CONSEQUENCE OF <i>Metastasis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>R/F Hemoplegia Diabetes</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i> </i>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>June 10 1968</i> to <i>Oct 26 1968</i> , that (I) (we) last saw the deceased alive on <i>Oct 26 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Jamshid Hamed M.D.</i>	DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>Oct 29 1968</i>	
22d. PHYSICIAN'S NAME (Type) Jamshid Hamed M.D.	22e. ADDRESS 204 E. Joppa road				
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 10/30/68	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cem.	23d. LOCATION (City or Town) Baltimore, Maryland	(County) 	(State)
24. FUNERAL DIRECTOR C.F. EVANS & SON	ADDRESS 8802 Harford Rd.	25a. REC'D BY REGISTRAR OCT 29 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

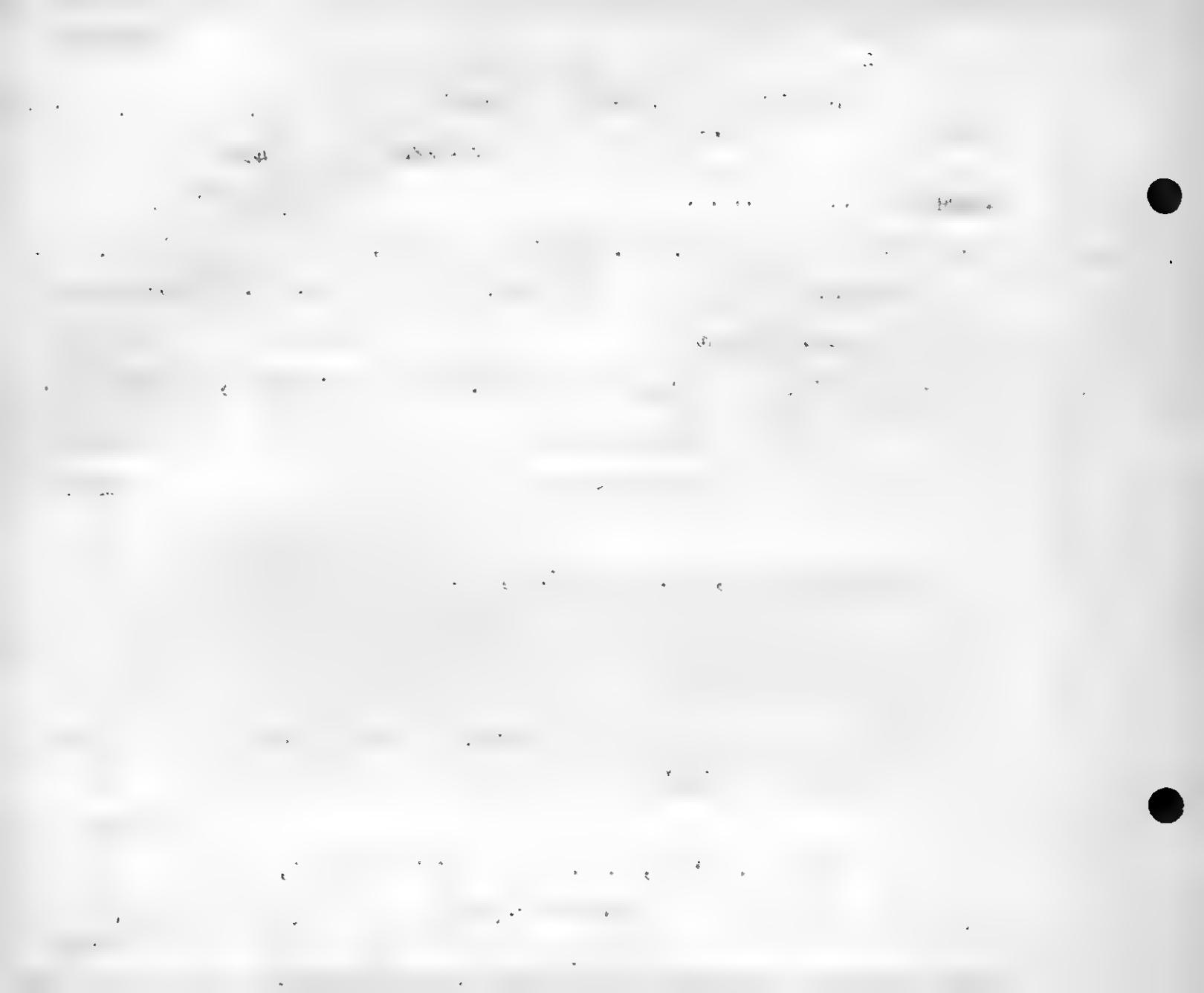
13912

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

CERTIFICATE OF DEATH

13923

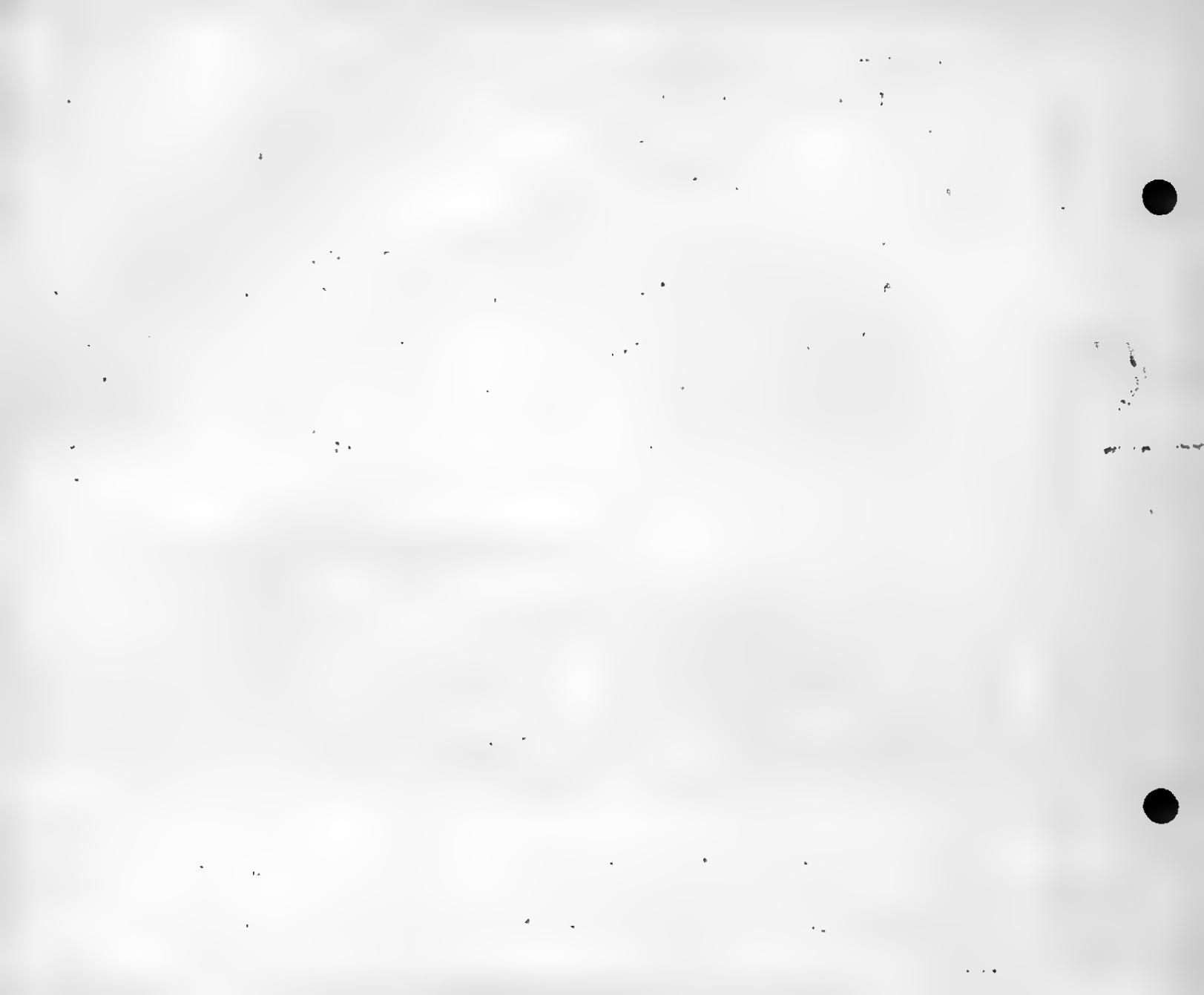
1 DECEASED-NAME (Type or print)			First STANLEY	Middle VINSON	Last BAREFOOT	2a. DATE OF DEATH Month 10	Day 3	Year 68	2b. HOUR 1:30AM			
3 SEX MALE		4 RACE NEGRO	5. DATE OF BIRTH 12/25/24			6 AGE (In years last birthday) 43		7. IF UNDER 1 YEAR MONTHS DAYS				
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9 COUNTY OF DEATH BALTIMORE COUNTY,			IF UNDER 24 HRS. MONTHS HOURS MIN			
10 CITY OR TOWN OF DEATH FORT HOWARD		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) VET. ADM. HOSPITAL			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) PRESSER			12b KIND OF BUSINESS OR INDUSTRY TAILOR SHOP				
13a U.S. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE		13c CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES	13e STREET AND NUMBER 2006 W. Fayette Street					
14 FATHER'S NAME First Linwood		Middle Barefoot	Last	15. MOTHER'S MAIDEN NAME First Bertha			Middle	Last Moore				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown YES		16b. SOCIAL SECURITY NO WW II		17 INFORMANT 243 20 47 89 CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.			Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH RECENT			
16 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. 163X (b) CARCINOMA, LEFT LUNG DUE TO, OR AS A CONSEQUENCE OF (c)									UNKNOWN			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) PULMONARY EMPHYSEMA, MARKED BILATERAL, OLD												
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.			City or Town	County	State		
22a. I certify that (X) (this hospital) attended the deceased from 8/18/68 , 19 68 , to 10/3/68 , 19 68 , that (✓) (we) last saw the deceased alive on 10/3/68 , 19 68 , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) did (X) view the body after death.												
22b. SIGNATURE <i>Erhard J. Bunyan M.D.</i>		22c. DEGREE ATTENDING PHYS.			22d. ADDRESS VAH FORT HOWARD, MARYLAND			22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22f. DATE SIGNED 10/3/68	
22d. PHYSICIAN'S NAME (Type)		23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 10-7-68			23c. NAME OF CEMETERY OR CREMATORIAL BALTIMORE NATIONAL			23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR <i>E. Bailey, Dyer.</i>		25a. ADDRESS KELSON FUNERAL HOME			25b. DATE OCT 4 1968			25c. REGISTRATION SIGNATURE <i>Erhard J. Bunyan M.D.</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH												13924
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR			
THAD			OTIS	BARNES		Month	10	Day	9	Year	68 1:40 P.M.	
3. SEX			4. RACE	5. DATE OF BIRTH			6. AGE (in years last birthday)			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male			Negro	2. 27. 1907			61 YRS.					
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			
Virginia			USA						Baltimore County			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital name street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Mount Wilson			Mount Wilson State Hosp.			Lumberer						
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER			
Md.			Baltimore			NO			339 W. Biddle St.			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last	
CARY					BARNES	BELLE					DELOATCH	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address			
No			24-09-7680			Medical Records, Mt. Wilson State Hosp.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Far advanced pulmonary cavity tuberculosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)												
MEDICAL CERTIFICATION		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
								YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from <u>8:24</u> , 19 <u>67</u> , to <u>10-9-1968</u> , that (I) (we) last saw the deceased alive on <u>10-9-1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) <u>not</u> view the body after death.												
22b. SIGNATURE		<u>William Newcomer</u>				DEGREE	ATTENDING PHYS.	<input type="checkbox"/> MED DIRECTOR	<input checked="" type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <u>10.9.1968</u>		
22d. PHYSICIAN'S NAME (Type)		William Newcomer, M.D.				22e. ADDRESS Mount Wilson, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>Burial Oct. 14 1968</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>CARVER Cemetery</u>				23d. LOCATION (City or Town) <u>Sykesville</u>		(County) (State) <u>MD VA</u>		
24. FUNERAL DIRECTOR		ADDRESS <u>Charles R. Lane 802 Madison Ave</u>				25a. REC'D BY REGISTRAR <u>Oct 14 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13925

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1	13814				13925			
1. DECEASED NAME (Type or print) <i>Louis</i> First <i>(Lee)</i> Middle <i>A</i> Last <i>Basford</i> 2. DATE OF DEATH Month <i>Oct</i> Day <i>6</i> Year <i>68</i> 2b. HOUR <i>1145 P.M.</i>								
3. SEX <i>M</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>12-26-95</i>		6. AGE (in years last birthday) <i>72 yrs</i>		
						IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i> HOURS <i>0</i> MIN <i>0</i> IF UNDER 24 HRS. MONTHS <i>0</i> DAYS <i>0</i>		
7a. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>BALTIMORE</i>		
10 CITY OR TOWN OF DEATH <i>RANDALLSTOWN</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>BALTIMORE CO. GEN. HOSP</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>SPEECH THERAPIST</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Balto 21209</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE <i>MARYLAND</i>		13b. COUNTY <i>BALTIMORE</i>		13c. CITY OR TOWN <i>BALTIMORE</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME First <i>GEORGE</i> Middle <i>M.</i> Last <i>Basford</i>		15. MOTHER'S MAIDEN NAME first <i>Mary J.</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>		16b. SOCIAL SECUR.TY NO <i>214-209-79</i>		17. INFORMANT <i>Vol. H. M. Basford, 2002 Mosby Rd.</i>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebro-vascular accident.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). (b) <i>Cerebral thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF (c)								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>CA of Prostate & metatarsis.</i>								
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BLDG., ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>9-16</i> , 19 <i>68</i> , to <i>10-6</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>10-6</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Boon Vanasin</i>		DEGREE ATTENDING PHYS.		MED. DIRECTOR		STAFF PHYS.	22c. DATE SIGNED <i>Oct 6, 68</i>	
22d. PHYSICIAN'S NAME (Type) <i>Boon VANASIN</i>		22e. ADDRESS <i>Baltimore County General Hosp</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>October 9, 1968</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Lorraine Park</i>		23d. LOCATION (City or Town) <i>Baltimore</i> (County) <i>Md.</i> (State)		
24. FUNERAL DIRECTOR <i>Loring Byers Funeral Service, 8728 Liberty Rd.</i>		ADDRESS <i>Randallstown, Md. 21191</i>		25a. RECEIVED BY REGISTRAR DATE <i>OCT. 9 1968</i>		25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

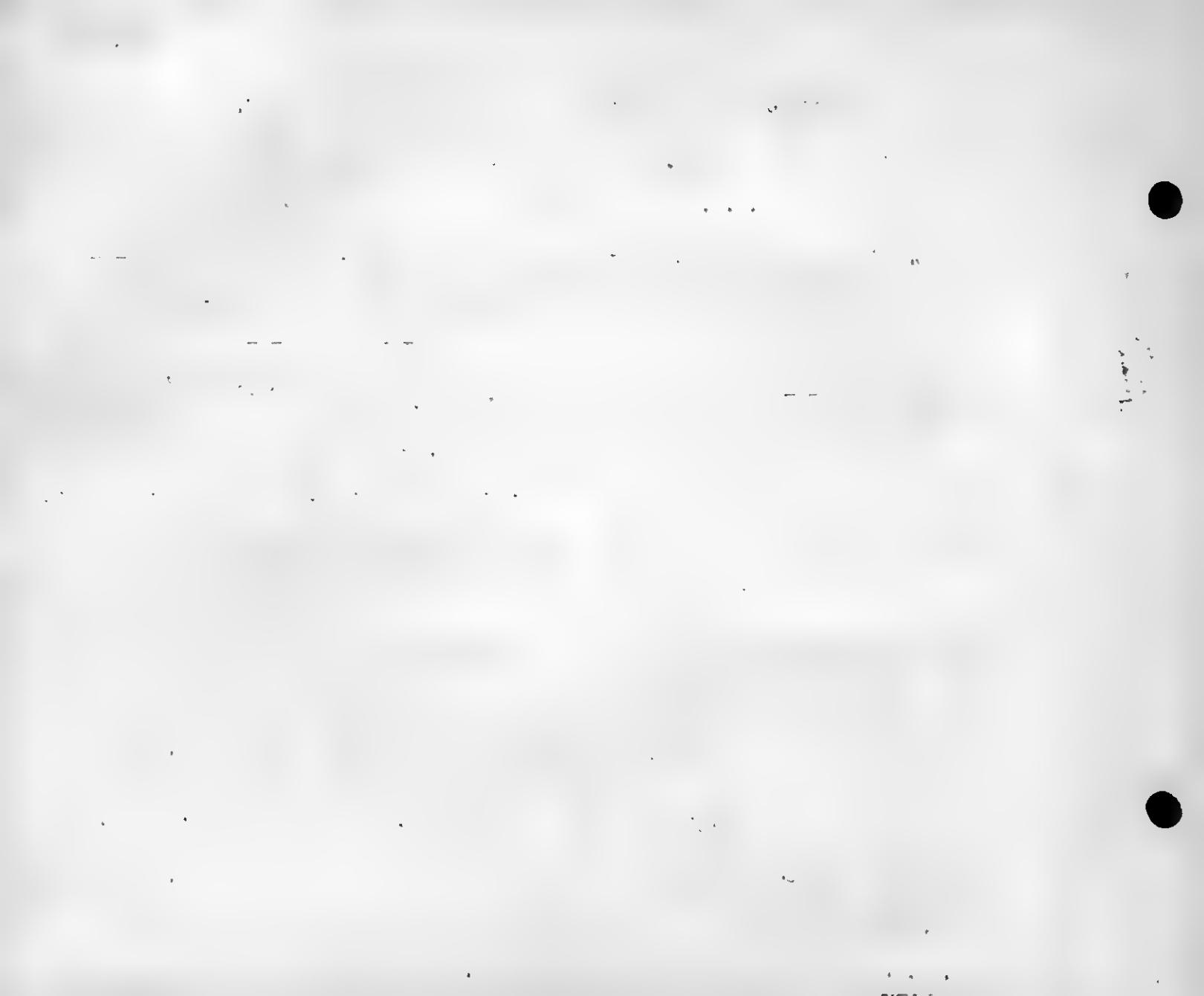
13926

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. If page 3 is lost, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First Margaret	Middle Basile	Last	2a. DATE OF DEATH Month Oct.	Day 4	Year 68	2b. HOUR 6 A.M.
3 SEX Female	4 RACE Cauc.	5. DATE OF BIRTH 8 OCT 1897		6. AGE (In years last birthday) 70	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	IF UNDER 24 MRS. HOURS
7a BIRTHPLACE (State or foreign country) Italy	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore,	Md			
10 CITY OR TOWN OF DEATH Catonsville	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) House in the Pines		12a. OCCUPATION (Kind of work done during most of working life, even if retired) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY ---		
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland	13b COUNTY Baltimore	13c CITY OR TOWN Baltimore	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER 8222 Scotts Level Road			
14 FATHER'S NAME UNKNOWN	First MIDDLE Last	15. MOTHER'S MAIDEN NAME First Middle Last Termine					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes	16b. SOCIAL SECURITY NO. 416 10 6318A	17 INFORMANT Mrs. Mary Levenstein	Baltimore, Maryland 21202 8222 Scotts Level Road				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 19. MEDICAL CERTIFICATION None 20. DATE OF OPERATION None 21b. CONDITION FOR WHICH OPERATION WAS PERFORMED 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED					
21d. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory (OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from 10/4/68, to 10/4/68, that (I) (we) last saw the deceased alive on 10/4/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Maurice Feldman	DEGREE ATTENDING PHYS.	22c. MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22d. DATE SIGNED 10/5/68			
22d. PHYSICIAN'S NAME (Type) Maurice Feldman	22e. ADDRESS 6610 Cross Country Blvd.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Oct 68	23c. NAME OF CEMETERY OR CREMATORIAL Holy Redeemer Cemetery	23d. LOCATION (City or Town) Baltimore, Maryland	(County)	(State)		
24. FUNERAL DIRECTOR J. E. Lowell Lemmon	ADDRESS 4611 Park Heights Ave.	25a. REC'D BY REGISTRAR DATE OCT 8 1968	25b. REGISTRAR'S SIGNATURE Charles Jagger				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13927

13916

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Please send 2 and 2 to the State Dept. of Health prior to burial, cremation, or removal, and bury event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First	Middle	Last	20. DATE OF DEATH Month	Doy	Year	2b. HOUR IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
		FRANK	G.	BASKETTE	OCTOBER	21	1968	2:37A M			
3. SEX		4. RACE	5. DATE OF BIRTH		6. AGE (In years lost birthday)						
MALE		WHITE	MARCH 10, 1907		61 YRS.						
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
VIRGINIA		U.S.A.				BALTIMORE					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. US-JAI OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
TOWSON		ST. JOSEPH HOSPITAL		Floorman		BETH. STEEL					
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
MARYLAND		Baltimore		Dundalk		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		6701 ROBERTS AVE. #21222			
14. FATHER'S NAME First		Middle	Last	15. MOTHER'S MAIDEN NAME First		Middle		Last			
James		R.	Baskette	Ninnie				Saunders			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT (Wife)		Address					
No		213-07-6122		Mrs. Bessie G. Baskette, 6701 Roberts Ave.		Dundalk, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure											
49dx DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Cor pulmonale											
DUE TO, OR AS A CONSEQUENCE OF (c) Diffuse pulmonary emphysema and fibrosis											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 20, 1968, to October 21, 1968, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 21, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Ines Ciliani</i>		DEGREE		ATTENDING PHYS.		MED. DIRECTOR		STAFF PHYS.		22c. DATE SIGNED 10/21/68	
22d. PHYSICIAN'S NAME (Type)		Ines Ciliani, M.D.		22e. ADDRESS		7620 York Rd., Towson, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/24/68		23c. NAME OF CEMETERY OR CREMATORIUM Oak Lawn Cemetery		23d. LOCATION (City or Town) Baltimore, Maryland		(County)		(State)	
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		ADDRESS		25a. REC'D BY REGISTRAR OCT 24 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

13928

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers page 2 and 3, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First VINCENT	Middle J.	Lost BATTAGLIA	2a. DATE OF DEATH Month 10 Day 31 Year 1968	2b. HOUR 0:35M
3 SEX Male	4 RACE Caucasian	5. DATE OF BIRTH 1/11/1908		6. AGE (in years lost birthday) 60 yrs.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (State or foreign country) New York N.Y.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9 COUNTY OF DEATH Baltimore		
10. CITY OR TOWN OF DEATH Towson	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Med. Center	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Baltimore	13c CITY OR TOWN Cockeysville	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER 10304 Malcolm Circle	
14. FATHER'S NAME First Salvatoria	Middle Battaglia	Last Peppena Lodota	15 MOTHER'S MAIDEN NAME First Middle Last		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (or unknown) W.W.II	16b SOCIAL SECURITY NO. 082 01 8972	17 INFORMANT Hospital Records	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic bronchogenic carcinoma					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1621 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
(b) DUE TO, OR AS A CONSEQUENCE OF					
(c) DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1621					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office, building etc.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (This hospital) attended the deceased from 10/19, 1968, to 10/31, 1968, that (I) (we) last saw the deceased alive on 10/31, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Charles C. Brown, M.D.	22c. DEGREE M.D.	ATTENDING PHYS <input type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input checked="" type="checkbox"/>	DATE SIGNED 11/1/68
22d. PHYSICIAN'S NAME (Type) Charles C. Brown, M. D.	22e. ADDRESS Greater Baltimore Medical Center				
23a. BURIAL, CREMATION, REMOVAL (Specify) Mausoleum	23b. DATE Nov. 4, 68	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Dulaney Valley	23d. LOCATION (City or Town) (County) (State) Cockeysville, Baltimore, Md.		
24. FUNERAL DIRECTOR William Cook-Brooks Towson, Inc.	1050 York Rd. Towson, Md. 21204	25a. REC'D BY REGISTRAR NOV 4 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

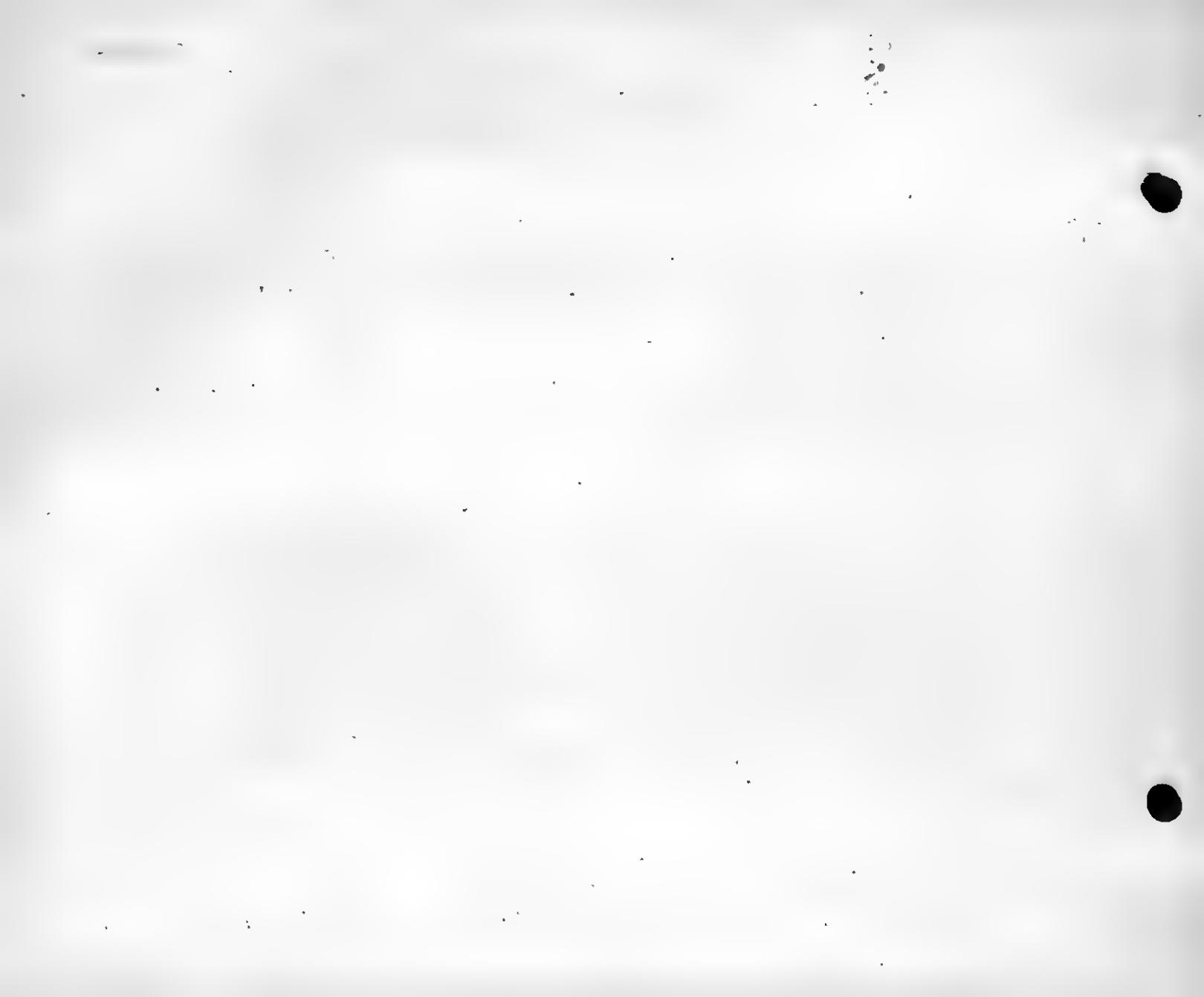
CERTIFICATE OF DEATH

13918

13929

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)				First Douglas	Middle Wesley	Last Baugher	2a. DATE OF DEATH Month 10	Day 27	Year 68	2b. HOUR 5: PM							
3. SEX Male		4. RACE White		5. DATE OF BIRTH 1/28/51			6. AGE (in years less than birthday) 67 yrs		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS						
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		9. COUNTY OF DEATH Baltimore		10. CITY OR TOWN OF DEATH Owings Mills		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rosewood State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) none		12b. KIND OF BUSINESS OR INDUSTRY none	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Carroll		13c. CITY OR TOWN Union Bridge		13d. INSIDE CITY LINE TSP YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Route #2									
14. FATHER'S NAME First Harry		Middle D	Last Baugher	15. MOTHER'S MAIDEN NAME First Gol'die		Middle H	Last Marsh										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT none		Address Rosewood Records Owings Mills, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration Pneumonia</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
3459 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Spastic quadriplegia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Epilepsy</u> .																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1b)													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State							
22a. I certify that (I) (this hospital) attended the deceased from <u>10-27, 1968</u> , to <u>10-27, 1968</u> , that (I) <input type="checkbox"/> last saw the deceased alive on <u>10-27, 1968</u> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.																	
22b. SIGNATURE <u>Massoud Kaye</u>		DEGREE ATTENDING PHYS.		<input type="checkbox"/> MED. DIRECTOR		<input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED <u>10-28-68</u>									
22d. PHYSICIAN'S NAME (Type)		MASSOUD KAYE		22e. ADDRESS Rosewood State Hospital, Owings Mills													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/30/68		23c. NAME OF CEMETERY OR CREMATORIAL MEADOW BRANCH CEM. WESTMINSTER, MD		23d. LOCATION (City or Town) Westminster		(County)		(State)							
24. FUNERAL DIRECTOR J. S. Myers Jr., Westminster, Md.		ADDRESS		25a. RECD. BY REGISTRAR NOV 1 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge											



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13930

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Please sign page 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First <i>hours</i>	Middle <i>Morgan</i>	Last <i>Beall, Sr.</i>	2a. DATE OF DEATH Month <i>OCTOBER</i>	Day <i>24</i>	Year <i>1968</i>	2b. HOUR <i>1:29 AM</i>
3. SEX MALE	4. RACE White	S. DATE OF BIRTH <i>6-12-99</i>	6. AGE (In years last birthday) <i>69</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) <i>MD.</i>	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Baltimore</i>				
10. CITY OR TOWN OF DEATH <i>Randallstown</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Baltimore County Gen.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Groceryman</i>			
13a. U.S. OR AL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD	13b. COUNTY Balto	13c. CITY OR TOWN <i>woodlawn</i>	13d. INSUR. CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER <i>6500 Lechner St</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Grocery</i>		
14. FATHER'S NAME First <i>William</i>	Middle <i>Beall</i>	Last <i>1920</i>	15. MOTHER'S MAIDEN NAME First Middle Last <i>Lora</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO. <i>219-25-4128</i>	17 INFORMANT <i>Chart</i>	Address <i>Hospital</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) CONGESTIVE HEART FAILURE 4129 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO SCLEROTIC HEART DISEASE Conditions, if any which gave rise to immediate cause (o), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11 Days							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(o) 4200 BRONCHOPNEUMONIA							
19a. DATE OF OPERATION 4200	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from OCT 13, 1968 , to OCT 24, 1968 , that (I) (we) last saw the deceased alive on OCT 24, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Fausto G. Aquino Jr.</i>	DEGREE ATTENDING PHYS	<input type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 10/24/68			
22d. PHYSICIAN'S NAME (Type) FAUSTO G. AQUINO JR.	22e. ADDRESS BALTO. COUNTY GEN. HOSPITAL						
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 10-28-68	23c. NAME OF CEMETERY OR CREMATORIAL woodlawn	23d. LOCATION (City or Town) woodlawn	(County) Md.	(State) Md.		
24. FUNERAL DIRECTOR Charles J. Muller	ADDRESS 2101 Ludenick Ave	25a. REC'D BY REGISTRAR Oct 28 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items#13c&eFilm#G407 12/4/68 v CERTIFICATE OF DEATH

13931

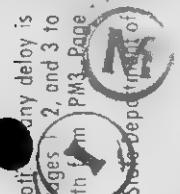
10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED NAME 13520 IRA				First	Middle	Last	2a. DATE OF DEATH Month 10 Day 2 Year 68	2b. HOUR 4:30
3. SEX MALE		4. RACE White	S. DATE OF BIRTH Aug 17, 1891	6. AGE (In years last birthday) 77 yrs		IF UNDER 1 YEAR MONTHS 7 DAYS 14	IF UNDER 24 HRS HOURS 4 MIN 30	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore				
10. CITY OR TOWN OF DEATH Cockeysville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Bonnie Blink Masonic Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Frederick Fireman			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md		13b. COUNTY Frederick	13c. CITY OR TOWN Burkittsville	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 11101 1/4 16th Street			
14. FATHER'S NAME ALFRED		Middle Beatty	Last MARY	15. MOTHER'S MAIDEN NAME Fauble				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO 219-20-6719		17. INFORMANT Address	Masonic Home			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4109		Coronary artery occlusion					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		DUE TO, OR AS A CONSEQUENCE OF Artherosclerotic heart disease						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
4001		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
19a. DATE OF OPERATION		21a. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) TIME OF INJURY HOUR A.M. Month Day Year P.M. 19						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) While at work			21c. LOCATION Street or R.F.D. No 4001	City or Town Cockeysville, MD	County Maryland	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>					State Maryland			
22a. I certify that (I) (this hospital) attended the deceased from 8/28/1968 to 8/28/1968 , that (I) (we) last saw the deceased alive on 8/28/1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death								
22b. SIGNATURE Jamshed Faizan M.D.		DEGREE M.D.	ATTENDING PHYS <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input checked="" type="checkbox"/>	22c. DATE SIGNED 12/4/68		
22d. PHYSICIAN'S NAME (Type) JAMSHED FAIZAN M.D.		22e. ADDRESS Cockeysville, MD Masonic Home						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 10-4-1968	23c. NAME OF CEMETERY OR CREMATORIAL Mr. Oliver Cemetery		23d. LOCATION (City or Town) Frederick	(County) Maryland	(State)	
24. FUNERAL DIRECTOR John B. Banks		ADDRESS 1050 York Rd	25a. REC'D BY REGISTRAR OCT 7 1968		25b. REG STRR'S SIGNATURE Charles Judge			



FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with 1 pm PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
13922 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13932

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b HOU.R OCTOBER 31 1968 M
Annetta M. Becker										
3 SEX <i>Female</i>	4 RACE <i>White</i>	5 DATE OF BIRTH <i>July 6, 1920</i>	6 AGE (in years last birthday) <i>48 yrs</i>	F UNDER MONTHS	YEAR DAYS	IF UNDER 24 HRS HOURS	MIN			2d HOUR 35 AM
7a BIRTHPLACE (State or foreign country) <i>BALTO. MD.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore Co.</i>				
10 CITY OR TOWN OF DEATH <i>Baltimore</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>St. Joseph's Hosp.</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Secretary</i>			12b KIND OF BUSINESS OR INDUSTRY <i>W.C.O.</i>		
13a USUAL RESIDENCE (Where deceased resided, if institution admission) STATE <i>M.D.</i>		13b COUNTY <i>Baltimore</i>		13c CITY OR TOWN <i>Baltimore</i>	13d INS. DE CTTY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e STREET AND NUMBER <i>12 Lyndale Avenue</i>			
14. FATHER'S NAME <i>Louis Becker</i>		15. MOTHER'S MAIDEN NAME <i>Lydia Schilpp</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16b SOCIAL SECURITY NO <i>212-18-5020</i>		17 INFORMANT <i>Mrs. Lydia Postuszny - 42 Lyndale Ave.</i>		ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Excessive Intake of Porridge</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Excessive Intake of Porridge</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Excessive Intake of Porridge</i>										5 Days
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>9108</i>										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED						20 AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
21a EXTERNA CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i>WHILE AT WORK</i>		21b TIME OF INJURY Month, Day, Year HOUR A.M. <i>P.M. 19</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Autopsy</i>						
21d INJURY OCCURRED WHILE NOT WHILE AT WORK		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No.			City or Town	County	State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										22b DATE SIGNED <i>10/31/68</i>
ACTUAL SIGNATURE <i>Charles F. O'Donnell, M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <i>Charles F. O'Donnell, M.D.</i>										ADDRESS (Street, city, town, or county) <i>Baltimore, Maryland</i>
23a BURIAL, CREMATON, REMOVAL (Specify) <i>Burial</i>		23b DATE <i>11-4-68</i>		23c NAME OF CEMETERY OR CREMATORIUM <i>Parkwood Cemetery</i>			23d LOCATION (City or Town) (County) (State) <i>Baltimore, Maryland</i>			
24. FUNERAL DIRECTOR		ADDRESS <i>John C. Miller Inc-615 Belair Rd. -21206</i>			25a RECEIVED BY REGISTRAR DATE <i>NOV 6 1968</i>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13933

13822

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. In any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

I. DECEASED NAME (Type or print)	First Martin	Middle M. (BENEDIK)	Last Benedict	2a. DATE OF DEATH Month October	Day 24, 1968	2b. HOUR 10:25 a.m.
3. SEX male	4. RACE white	5. DATE OF BIRTH Oct. 15, 1899		6. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Penns.	7b. CITIZEN OF WHAT COUNTRY? U. S.	8. MARRIED NEVER MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore		
10. CITY OR TOWN OF DEATH Catonsville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.	13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMIT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER none		
14. FATHER'S NAME Anthony Benedict	First Middle Last	15. MOTHER'S MAIDEN NAME First Mary Puscrik		Middle	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO 382-01-6298T	17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute myocardial Infarction</i> APPROXIMATE INTERVAL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Hypertension</i> BETWEEN ONSET AND DEATH						
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Primary artery disease, arteriosclerosis</i>						
DUE TO, OR AS A CONSEQUENCE OF (c) <i>decoction</i>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Empty senescent - Diabetes mellitus.</i>						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town		County	State
22a. I certify that (s) (this hospital) attended the deceased from Nov. 29, 1961, to Oct. 24, 1968, that (I) (we) last saw the deceased alive on Oct. 24, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Rafael H. Marin</i>	DEGREE ATTENDING PHYS.	MED DIRECTOR	STAFF PHYS.	22c. DATE SIGNED 10-24-68		
22d. PHYSICIAN'S NAME (Type) Rafael H. Marin, M.D.	22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10-25-68	23c. NAME OF CEMETERY OR CREMATORIAL Glenwood Cemetery	23d. LOCATION (City or Town) Glenwood	(County) Baltimore	(State) Md.	
24. FUNERAL DIRECTOR Foley Corrigan, F.H. - Catonsville, Md.	ADDRESS Foley Corrigan, F.H. - Catonsville, Md.	25a. REC'D BY REGISTRAR OCT 31 1968	25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13928

13934

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First <i>Vernon</i>	Middle <i>M</i>	Last <i>Benner</i>	2a. DATE OF DEATH Month <i>October</i>	Day <i>30</i>	Year <i>1968</i>	2b. HOUR <i>10 AM</i>	
3. SEX <i>M</i>	4 RACE <i>W</i>	5. DATE OF BIRTH <i>12-30-05</i>		6. AGE (In years last birthday) <i>62</i>	IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS. DAYS <i>0</i>	IF UNDER 24 HRS. HOURS <i>0</i>	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i>				
10. CITY OR TOWN OF DEATH <i>Randalls Town</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Baltimore Co. Gen. Hosp</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Bricklayer</i>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution STATE <i>Md.</i>	13b. COUNTY <i>--</i>	13c. CITY OR TOWN <i>Baltimore</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>534 South Bentallou</i>				
14 FATHER'S NAME First <i>FRANK</i>	Middle <i></i>	Last <i>Benner</i>	15. MOTHER'S MAIDEN NAME First Middle <i>Martha Tiepmann</i>		Last <i></i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Or unknown <i>No</i>	16b. SOCIAL SECURITY NO <i>217-03-5698</i>	17. INFORMANT <i>XXXXXX, Mrs. Blanca M. Benner</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs.</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypertension</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cardiovascular Disease</i> YEARS.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>443</i>								
19a. DATE OF OPERATION <i>443</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <i>While at work</i>		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>At home</i>					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY OFFICE BUILDING, ETC.) <i>Office Building</i>	21f. LOCATION Street or R.F.D. No <i>BC 811</i>	City or Town <i>Baltimore</i>		County <i>Maryland</i>	State <i></i>	
22a. I certify that (I) (this hospital) attended the deceased from <i>10-30</i> , 19 <i>68</i> , to <i>10-30</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>10-30</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Angeleita Spain</i>		DEGREE <i></i>	ATTENDING PHYS <input type="checkbox"/>	MED DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS <input checked="" type="checkbox"/>	22c. DATE SIGNED <i>10-30-68</i>		
22d. PHYSICIAN'S NAME (Type) <i>Angeleita Spain</i>		22e. ADDRESS <i>BC 811</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE <i>11-2-1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Loudon Park Cemetery</i>		23d. LOCATION (City or Town) <i>Baltimore, Maryland</i>	(County) <i></i>	(State) <i></i>		
24. FUNERAL DIRECTOR <i>Howard H. Hubbard, 4107 Wilkens Ave.</i>	ADDRESS <i>21229</i>	25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	DATE <i>NOV 4 1968</i>			
VR A15 30M REV. 1								



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

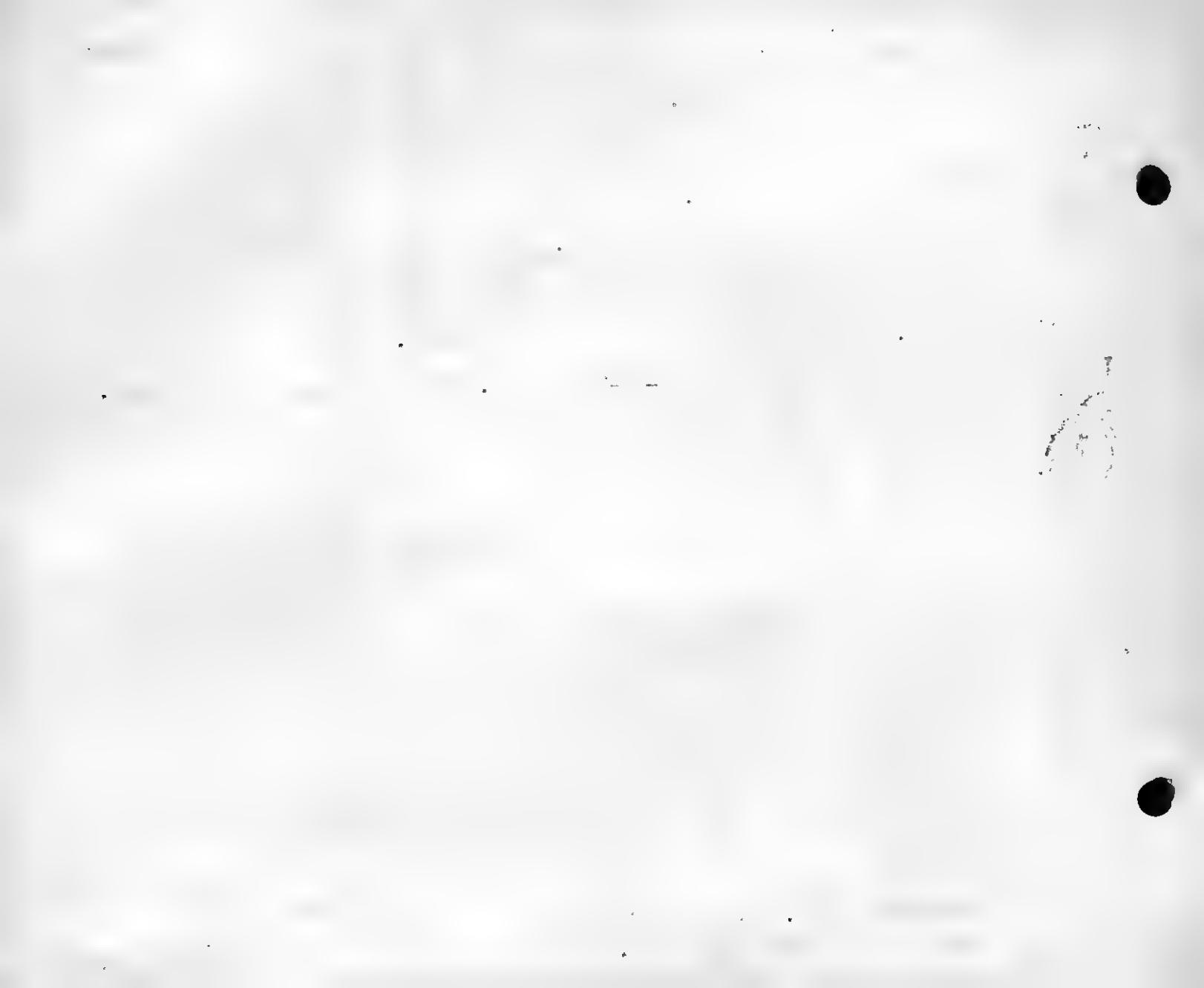
CERTIFICATE OF DEATH

13935

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Pursuant to the Funeral Director's Permit, the physician or attending physician may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Thereupon remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Oliver	Middle C.	Last Benton	20. DATE OF DEATH 10 Month 15 Day 68 Year	2b. HOUR 7pm
3. SEX Male	4. RACE White	S. DATE OF BIRTH 10-27-04	6. AGE (In years lost birthday) 65 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore County		
10. CITY OR TOWN OF DEATH Randallstown	11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Balto. Co. Gen. Hosp	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Salesman	12b. KIND OF BUSINESS OR INDUSTRY Sears		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland	13b. COUNTY Balto	13c. CITY OR TOWN Randallstown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Deer Park Road	
14. FATHER'S NAME First Wm. Oliver Benton	Middle Benton	Last Lost	15. MOTHER'S MAIDEN NAME Lucy V. New	Middle	Lost
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or <input checked="" type="checkbox"/> (If yes give war or dates of service)	16b. SOCIAL SECURITY NO 298-05-3748	17. INFORMANT Mrs. Isabel Lee Benton Deer Park Rd.	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Zerema</u> <u>5901</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Dysenteric Paroxysms</u> DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Oliver C. Paetz M.D.</u>	DEGREE ATTENDING PHYS	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 10-15-68	
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS				
23a. BURIAL, CREMATION, Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Specify	23b. DATE Oct. 18, 68	23c. NAME OF CEMETERY OR CREMATORIAL Rock Spring Cemetery, Bel Air	23d. LOCATION (City or Town) Belair Maryland	(County)	(State)
24. FUNERAL DIRECTOR Toring Byers	ADDRESS 8728 Liberty Rd. Randallstown	25a. FILED BY REGISTRAR OCT 18 1968	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

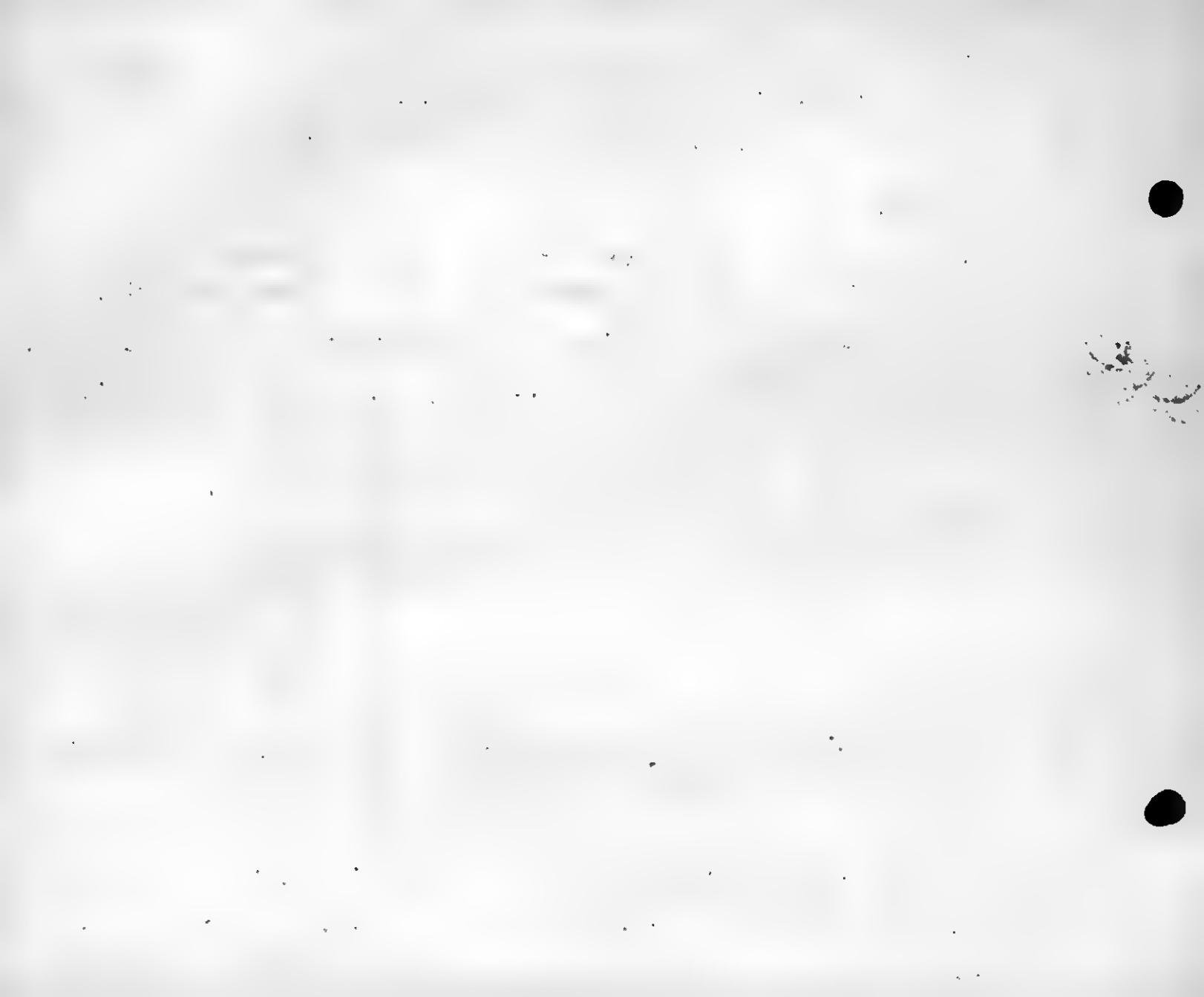


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13923

13936

1. DECEASED-NAME (Type or print)		First	Middle	Lost	2d. DATE OF DEATH '10 Month 6 Day 1968	2b. HOUR 504		
EVELYN ROSE BERRY								
3. SEX	F	4. RACE	NEGRO	S. DATE OF BIRTH	18-Aug-1908	6 AGE (In years less birthday) 60		
7. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH Baltimore County,			
MD.		US						
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Mount Wilson		Mt. Wilson St. Hosp.		HOUSEKEEPER				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY	13c CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER, ST. HANSON APTS	W 6 th ST.		
MD		FREDRICK FREDERICK						
14 FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME	First	Middle	Lost
FRANK JOSHUA HALL					MARGARET STELLA DORSEY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17 INFORMANT		Address		
No		UNKN		Records, Mt. Wilson State Hospital				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE LIVER FAILURE								
Approximate interval between onset and death								
5-11-8								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost								
(b) Post necrotic cirrhosis								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State	
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from 16 DEC 1966, to 6 Oct 1968, that <input type="checkbox"/> (we) last saw the deceased alive on 6 Oct 1968, and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) (did) (did not) view the body after death.								
22b. SIGNATURE William Newcomer		DEGREE	ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input checked="" type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 6 Oct 1968		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		Mount Wilson, Maryland				
William Newcomer, M.D.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-10-68	23c. NAME OF CEMETERY OR CREMATORIUM Mt. Zion	23d. LOCATION (City or Town) Mt. Airy Fred		(County) Fred		(State)
24. FUNERAL DIRECTOR		ADDRESS C.F. Hicks, 111 Frederick, Md		25a. REC'D BY REGISTRAR OCT 10 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



Item 23 Film G406 1/6/68 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13326

CERTIFICATE OF DEATH

13937

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the physician or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR 4:15 P.M.			
Donald Eugene Bianconi				10-30-68						
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH Jan. 16, 1950			6. AGE (In years last birthday) 18 yrs.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. COUNTY OF DEATH Baltimore						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7104 Eastbrook Ave.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Student		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 7104 Eastbrook Ave.						
14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME Ruth Belcher							
Charles Bianconi, Sr.										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO (If yes give war or dates of service) None	17. INFORMANT Charles Bianconi, Sr., 7104 Eastbrook Ave.	Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral mass			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mos.					
11 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (b) Hodgkin's Disease			5 years					
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
died		19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
MEDICAL CERTIFICATION		21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
X		21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 10-12-68 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (do) (did not) view the body after death.					1964, to 10-29, 1968, that (I) (we) last					
22b. SIGNATURE John B. Littleton MD		DEGREE	ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 10-30-68				
22d. PHYSICIAN'S NAME (Type)		John B. Littleton			22e. ADDRESS 7104 Old Northpoint Rd. Balto. Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/2/1968	23c. NAME OF CEMETERY OR CREMATORIUM Gardens of Faith Cem.			23d. LOCATION (City or Town) Baltimore		(County)	(State)	
24. FUNERAL DIRECTOR		ADDRESS Leonard J. Ruck, Inc., 5305 Harford Rd.			25a. RECD BY REGISTRAR DATE OCT 31 1968		25b. REGISTRAR'S SIGNATURE O. Charles Judge			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13827

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13938

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)	First	Middle	Lost	2a. DATE KNOWN OF ESTI. DEATH MATED	Month	Day	Year	2b. HOUR				
Lois		Benson	Birmingham	<input checked="" type="checkbox"/>	Oct	1	1968	8 PM				
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	HOURS	MIN.	2c. DATE PRONOUNCED DEAD Month	2d. HOUR Day	Year	2d. HOUR	
F	W	Aug 25 1903	65 yrs					Oct	1	1968	9 PM	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. COUNTY OF DEATH								
Maryland	U.S.A.			Baltimore								
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)			12a. JSJAL OCCUPATION (Kind of work done during most working life, even if retired)								
Towson	St. Joseph Hosp. DOA			At home								
13a. USUAL RESIDENCE (Where deceased lived at time of admission) STATE	13b. CITY OR TOWN	13c. INSIDE CITY LIMITS?	13e. STREET AND NUMBER									
Md	Balto City	Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	4122 Roland Ave								
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last					
Thomas	J	Benson		Bessie	H.		Burk					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO (If yes give war or dates of service)			17. INFORMANT	ADDRESS							
No	215-08-0137			Charles H. Birmingham	4122 Roland Ave							
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> APPROXIMATE INTERVAL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Sudden</u>												
DUE TO, OR AS A CONSEQUENCE OF (b) <u></u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4221</u>												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
MEDICAL CERTIFICATION		21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) 19						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Charles F. O'Donnell, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 10/1/68		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL Woodlawn		23d. LOCATION (City or Town) Woodlawn, Balt., Md.		(County)		(State)		
Burial		10/3/68										
24. FUNERAL DIRECTOR		ADDRESS		25a. REGISTERED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
Burgee Funeral Home		3631 Falls Rd.		OCT 7 1968		Charles Judge						
William R Kleiner												



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

13928

13939

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First ANNA	Middle Margaret	Last BLEAKLEY	2a. DATE OF DEATH Month October	Day 26	Year 1968	2b. HOUR 1:30 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH 8-12-1892		6. AGE (in years last birthday) 76	IF UNDER 1 YEAR MDNTHS YRS.		IF UNDER 24 HRS DAYS HOURS MIN
7d. BIRTHPLACE (State or foreign country) Baltimore	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore			
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife				
13a. USUAL RESIDENCE (Where deceased lived, if institutional) Residence before admission) Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Parkville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 3009 Acton Road 21234			12b. KIND OF BUSINESS OR INDUSTRY At Home
14. FATHER'S NAME Charles	Middle Resch	Last 	15. MOTHER'S MAIDEN NAME Elizabeth	Middle 	Last Wolf	Fermam	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. 215-09-2565	17. INFORMANT Husband	Address Harry F. Sr. Same				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Pulmonary emboli							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) Carcenoma of the Gall Bladder with metastasis							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (c) 							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 155							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from 10-21 , 19 68 , to 10-26 , 19 68 , that (I) (we) last saw the deceased alive on 10-26 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							22c. DATE SIGNED 10-26-68
22b. SIGNATURE Ines Cilliani	DEGREE MD	ATTENDING PHYS. <input type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>			
22d. PHYSICIAN'S NAME (Type) Ines Cilliani MD	22e. ADDRESS 7620 York Rd., Towson, Md. 21204						
23a. FUNERAL, CREMATION, Crematory Spec'd BURIAL	23b. DATE 10/29/68	23c. NAME OF CEMETERY, OR CREMATORIAL PARKWOOD	23d. LOCATION (City or Town) Baltimore	(County) Md.	(State)		
24. FUNERAL DIRECTOR Cliff Evans Jr.	ADDRESS 8802 Hanford Rd.	25a. RECD BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge	DATE OCT 29 1968			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

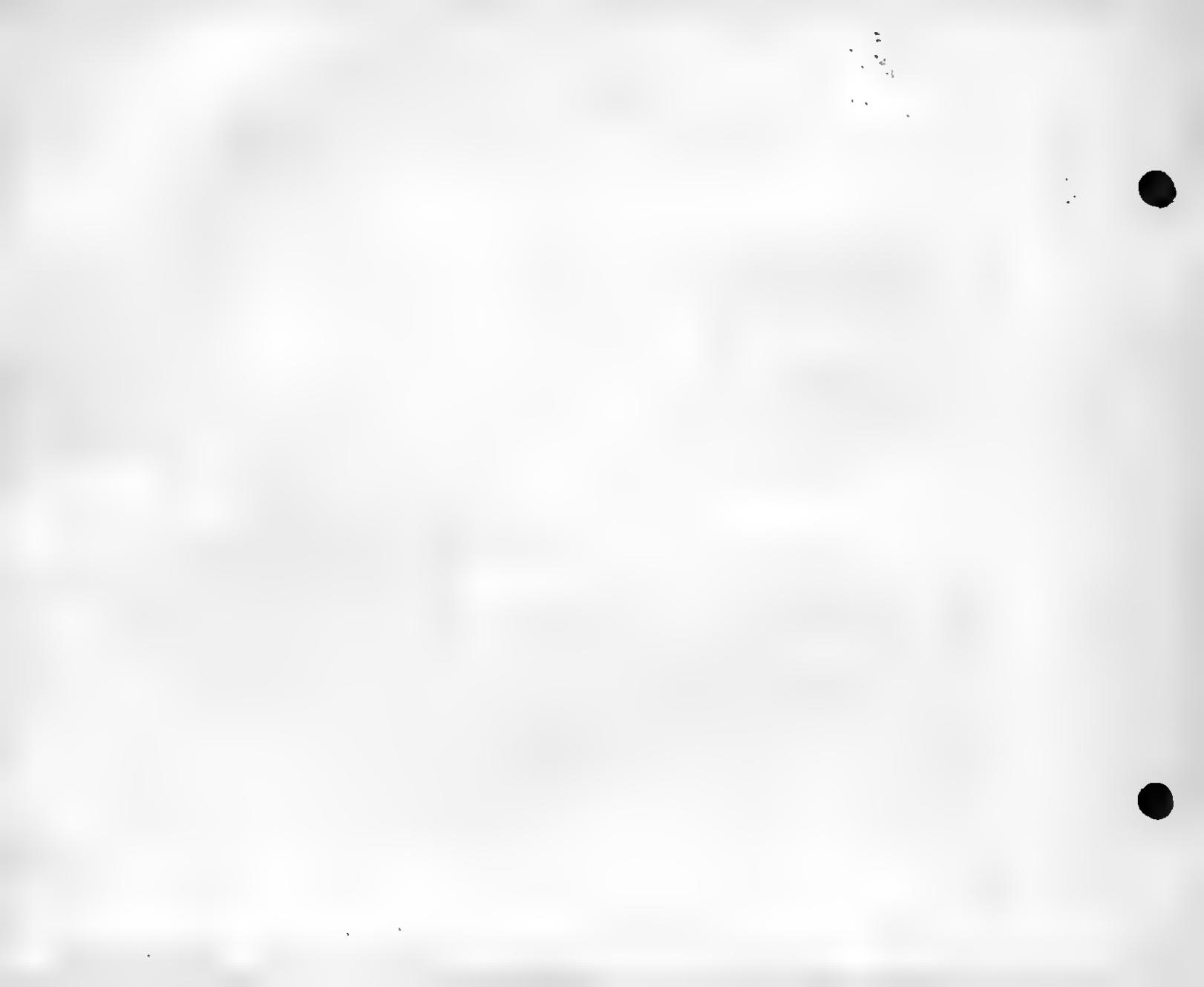
13940

13928

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial-transit permit. Then please remove from papers page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of the death.

1 DECEASED-NAME (Type or print)				First CLARA	Middle MAE	Last BLOOD	2a DATE OF DEATH Month Oct	10-14-68	2b. HOUR Year 1968
3 SEX 1		4 RACE 11		5. DATE OF BIRTH 5-24-1888		6 AGE (in years last birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Calgary, Alta.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Co., Md.			
10. CITY OR TOWN OF DEATH Towson		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Bellevue Hospital Towson		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Hausfrau		12b KIND OF BUSINESS OR INDUSTRY Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution Reside before admission) STATE Towson		13b. COUNTY Alta.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1026 Huntingdon Rd.			
14. FATHER'S NAME First Harry		Middle Keithley	Last Smith	15 MOTHER'S MAIDEN NAME First Anna		Middle Smith	Last Smith		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. —		17 INFORMANT Clara B Segares		Address 1026 Huntingdon Circle Towson, Md. 21204		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Left Ventricular Failure DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Heart Disease 10 Years? DUE TO, OR AS A CONSEQUENCE OF									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) —									
19a DATE OF OPERATION —		19b CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —			
21a ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) White		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. — 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.) —					
21d. INJURY OCCURRED at work <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) —		21f LOCATION Street or R.F.D. No. —		City or Town —		County —	State —
22a I certify that (I) (this hospital) attended the deceased from Nov. 1963 to Oct. 13, 1968 , that (I) (not) last saw the deceased alive on Oct. 12, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Keith A. Manley M.D.		DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED 10-14-68			
22d. PHYSICIAN'S NAME (Type) KEITH A. MANLEY		22e ADDRESS 2025, YORK ROAD, TIMONIUM							
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-17-68		23c. NAME OF CEMETERY OR CREMATORIAL Prado Ridge		23d. LOCATION (City or Town) Tiskesville		(County) MD	(State)
24 FUNERAL DIRECTOR IN "Cook-Brooks Towson		ADDRESS 1050 York Rd. Towson, Md.		25a. REC'D. BY REGISTRAR DATE OCT 15 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

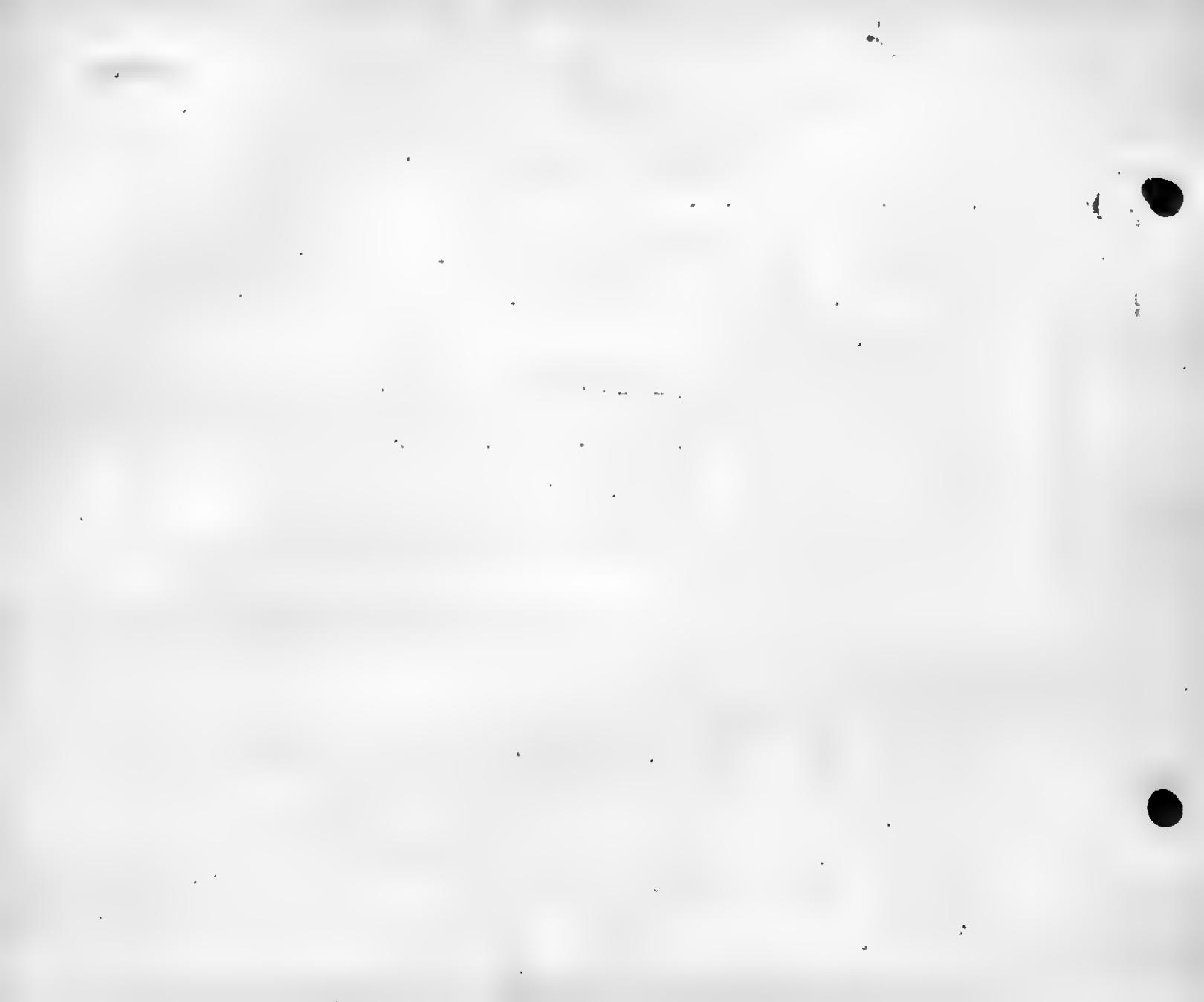
13930

13941

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First Lucy	Middle May	Lost Bortner	2a. DATE OF DEATH Month Oct Day 14 Year 1968	2b. HOUR 10:20 P.M.
3. SEX female		4. RACE white		5. DATE OF BIRTH Aug. 10, 1892		6. AGE (In years lost birthday) 76 yrs
7a. BIRTHPLACE (State or foreign country) Va.		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore	
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 4527 Keswick Road	
14. FATHER'S NAME George Herndon		15. MOTHER'S MAIDEN NAME Aida Mack				Lost
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. 212-03-3923		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4104 Myocarditis, a/c to me						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF (b) <i>De cavitatis ulcer is infected -</i>				
(c)		DUE TO, OR AS A CONSEQUENCE OF				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 420:						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from Nov. 14, 1959, to 10-14, 1968, that (I) (we) last saw the deceased alive on 10-14, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Vince J. Ricciello MD		DEGREE ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 10-14-68	
22d. PHYSICIAN'S NAME (Type) VICENTE J. RICCIOLI MD		22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-18-68	23c. NAME OF CEMETERY OR CREMATORIUM Woodlawn Cem		23d. LOCATION (City or Town) Woodlawn, Baltimore, Maryland	(County) (State)
24. FUNERAL DIRECTOR Burger Funeral Home B2/B6 Md		ADDRESS	25a. REC'D BY REGISTRAR DATE OCT 21 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13831

13942

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First <i>FRANCIS L.</i>	Middle <i></i>	Last <i>Boyce</i>	2a. DATE OF DEATH Month <i>Oct.</i>	Day <i>22</i>	Year <i>1968</i>	2b. HOUR <i>2:15 P.M.</i>			
3. SEX <i>MALE</i>		4. RACE <i>WHITE</i>		S. DATE OF BIRTH <i>3-14-85</i>	6. AGE (in years last birthday) <i>83</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>BALTIMORE</i>						
10. CITY OR TOWN OF DEATH <i>BALTIMORE, MD</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Summit Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>TRANSPORT</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>RET.</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution Res.dence before admission) STATE <i>Md.</i>		13b. CITY OR TOWN <i>BALTO</i>		13c. INSIDE CITY LIMITS <i>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></i>	13e. STREET AND NUMBER <i>316 Martingale Ave.</i>						
14. FATHER'S NAME First <i>GEO. BOYCE</i>		Middle <i></i>	Last <i></i>	15. MOTHER'S M AIDEN NAME First <i>KATE BULLOCK</i>		Middle <i></i>	Last <i></i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO. <i></i>		17. INFORMANT <i>STANLEY F. BOYCE</i>		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary artery occlusion</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>30 min</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>41</i>		DUE TO, OR AS A CONSEQUENCE OF <i>Coronary artery sclerosis</i>									
(b) <i></i>											
DUE TO, OR AS A CONSEQUENCE OF <i>Atherosclerotic Cardio Vasc. Disease</i>											
(c) <i></i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)											
21a. DATE OF OPERATION <i>4</i>		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i></i>		21c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i></i>					
21d. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <i></i>		21e. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>		21f. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i></i>							
21g. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21h. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <i></i>		21i. LOCATION Street or R.F.D. No. <i></i>		City or Town <i></i>		County <i></i>	State <i></i>		
22a. I certify that (I) (this hospital) attended the deceased from <i>Dec 31, 1960</i> , to <i>Oct 22, 1968</i> , that (I) (we) last saw the deceased alive on <i>Oct 22, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>HARRY J. KNIGHT, M.D.</i>		DEGREE <i></i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>10-22-68</i>					
22d. PHYSICIAN'S NAME (Type) <i>HARRY J. KNIGHT, M.D.</i>		22e. ADDRESS <i>416 Edmondson Ave., Balt., Md. 21209</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>10/25/68</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>LORRAINE</i>		23d. LOCATION (City or Town) <i>BALTO. CO. MD.</i>		(County) <i></i>		(State) <i></i>	
24. FUNERAL DIRECTOR <i>E. S. MACNAUL 301 FREDERICK AVE 712-25</i>		ADDRESS <i></i>		25a. REC'D BY REGISTRAR <i></i>		25b. REGISTRAR'S SIGNATURE <i>Clarkey Judge</i>		DATE <i>OCT 25 1968</i>			



Item 23b Film G406 11/1/68 kk MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12932

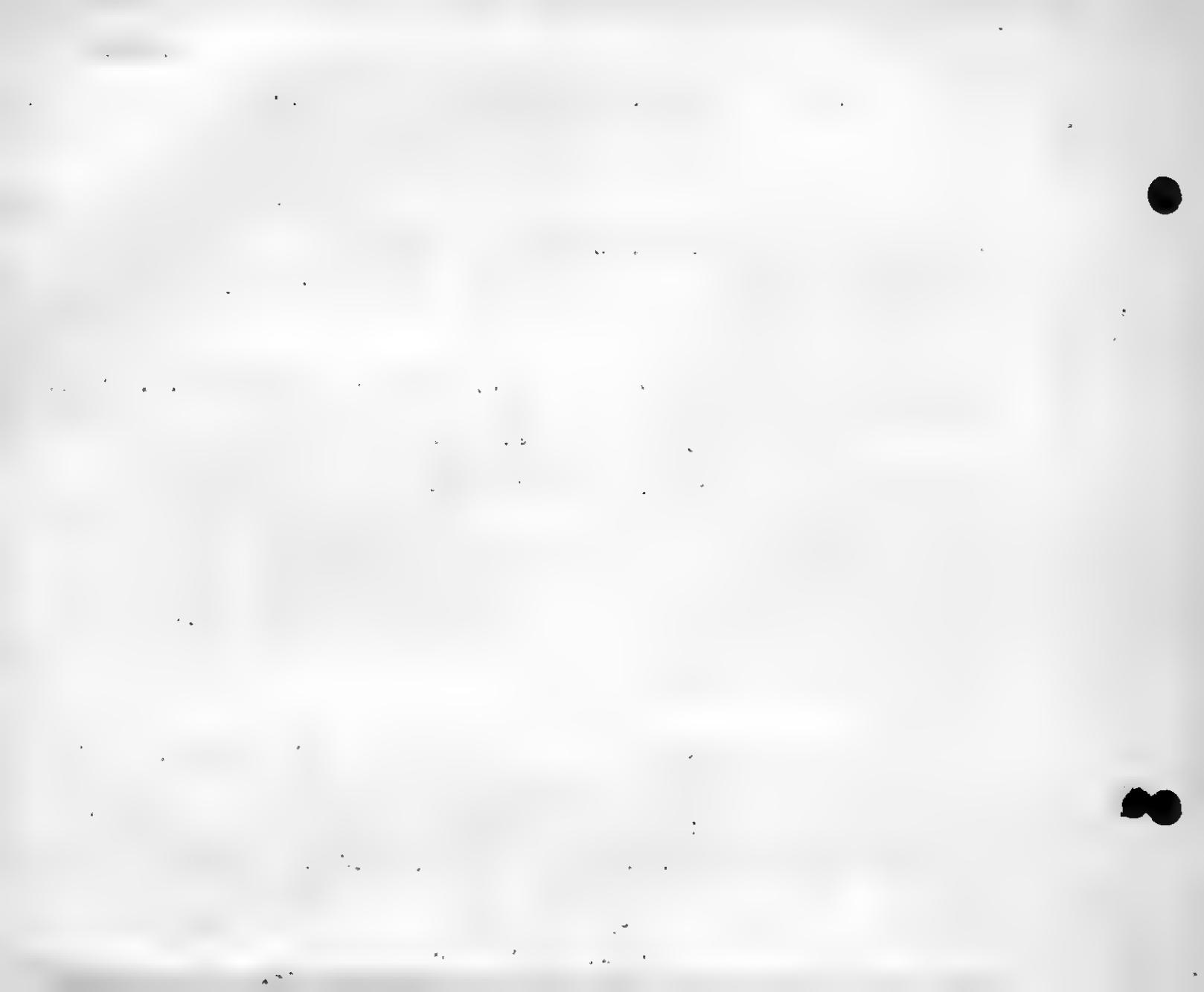
CERTIFICATE OF DEATH

13943

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and completely filled in by the attending physician or offending physician.

To FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in by the attending physician, then please remove carbon papers. Part 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Part 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First EDWARD	Middle N.	Last BOYER	2a. DATE OF DEATH Month OCTOBER	Day 23	Year 1968	2b. HOUR 9:30 A.M.
3 SEX MALE	4. RACE NEGRO	5. DATE OF BIRTH 11/20/98	6. AGE (In years last birthday) 69	IF UNDER 1 YEAR MONTHS YRS			
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CIT.ZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE COUNTY, Md				
10. CITY OR TOWN OF DEATH FORT HOWARD	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VET. AM. HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) LABORER	12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased admission) MARYLAND	13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 2601 Ulman Avenue			
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	16b. SOCIAL SECURITY NO WW I 217 07 25 72	17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.	Address	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral HEMORRHAGE 451.7 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
(b) CEREBRAL ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/> YES		
				<input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, nat./phy medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8/27/68 , 19 19 , to 10/23/68 , 19 19 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10/23/68 , 19 19 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> view the body after death.							
22b. SIGNATURE John Ami Orer m.d.		DEGREE ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED 10/23/68		
22d. PHYSICIAN'S NAME (Type) INFAN A. ORER, M. D.		22e. ADDRESS VAH FORT HOWARD, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE Oct. 28, 1968	23c. NAME OF CEMETERY OR CREMATORIAL BALTIMORE NATIONAL	23d. LOCATION (City or Town) BALTIMORE, MARYLAND	(County)	(State)	
24. FUNERAL DIRECTOR Irvin Carroll		ADDRESS HALSTEAD FUNERAL HOME	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE 1206 W. NORR AVE. BAL. 21 RE 00T 28 1968			
VR A15 30M REV.							



FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1(a). Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PMJ & Page 5 may be retained for your files.

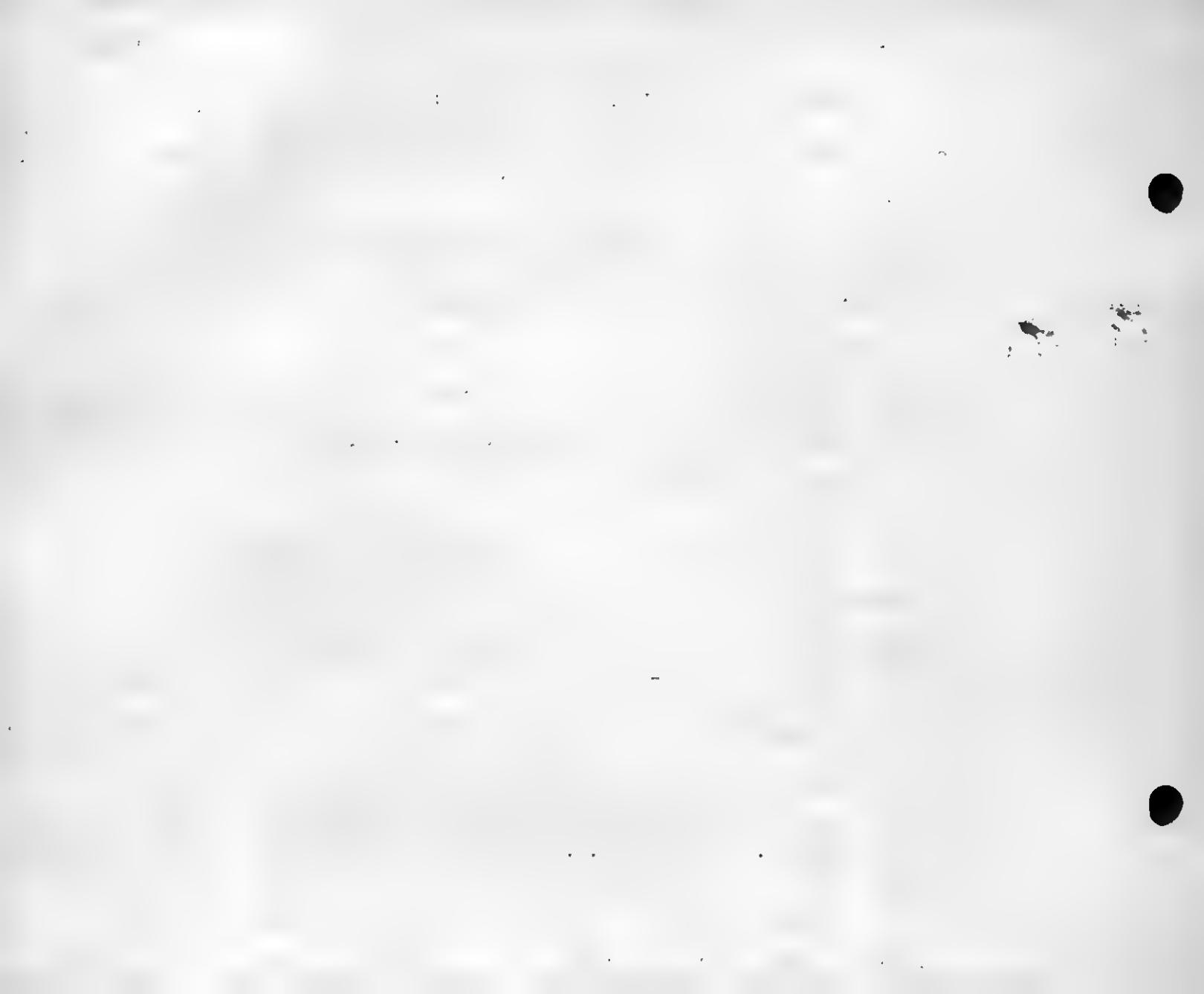
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 4 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
13933 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13944

1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN <input checked="" type="checkbox"/> Month Day Year DEATH ESTI DEATH MATED <input type="checkbox"/> 10-16 1968	2b HOUR <input type="checkbox"/> 3:00 P.M.	
WILLIAM	EDWARD	BRADY						
3 SEX	4 RACE	5 DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	2c DATE PRONOUNCED DEAD Month Day Year October 16, 1968	2d HOUR 3:00 P.M.	
Male	White	Oct 9 1925	43 YRS					
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	B MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH BALTIMORE					
Maryland	USA							
10. CITY OR TOWN OF DEATH Carney			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2919 Ontario Ave			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Drill Press Oper		12b KIND OF BUSINESS OR INDUSTRY Koppers Co
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13c CITY OR TOWN Baltimore			13d INS OR CITY LIMITS YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 2919 Ontario	
14 FATHER'S NAME David Brady			15. MOTHER'S MAIDEN NAME Katherine Phillips					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes. WW2			16b. SOCIAL SECURITY NO 219-22-8737			17. INFORMANT Family Records		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Shotgun wound of mouth</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 176x								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. ? P.M. 10-16 1968			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Shot self		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) basement			21f. LOCATION Street or R.F.D. No City or Town County State 2919 Ontario Baltimore Md.		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
22b. DATE SIGNED October 17, 1968								
CHIEF MEDICAL EXAMINER <input type="checkbox"/> MD ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 10-19-68			23c. NAME OF CEMETERY OR CREMATORIAL Parkwood Cem.		
24. FUNERAL DIRECTOR C.F. EVANS & SON 8802 Harford road			ADDRESS			23d. LOCATION (City or Town) (County) (State) Baltimore Maryland		
						23e. REC'D BY REGISTRAR DATE OCT 22 1968		
						23f. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. In any event, within 72 hours after death, this certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13936

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13945

1. DECEASED NAME (Type or print)	First A.	Middle STANLEY	Last BRAGER, SR.	2a. DATE OF DEATH Month OCTOBER Day 30, 1968 Year 1968	2b. HOUR 6 A.M.
3. SEX MALE	4. RACE WHITE	S. DATE OF BIRTH MAY 29, 1885	6. AGE (In years last birthday) 83 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) BALTIMORE, MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH BALTIMORE		
10. CITY OR TOWN OF DEATH PIKESVILLE	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MILFORD MANOR NURSING HOME	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) INVESTMENT	12b. KIND OF BUSINESS OR INDUSTRY BROKER		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 2601 MADISON AVENUE		
14. FATHER'S NAME First ALBERT	Middle A.	Last BRAGER	15. MOTHER'S MAIDEN NAME First BLEEMA	Middle	Last FRIEDENWALD
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT MR. A. STANLEY BRAGER, JR., 7039 CONCORD RD. #8	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Arteriosclerosis, cerebral</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4-14 3 years					
Conditions, if any, which gave rise to immediate cause (a). (b). stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c).					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 2-344 <u>Carcinoma of larynx</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Alan Bernstein</i>	DEGREE MD PHYS	ATTENDING <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 10/30/68		
22d. PHYSICIAN'S NAME (Type) ALAN BERNSTEIN	22e. ADDRESS 819 PARK AVENUE				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 10-31-68	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS BALTIMORE HEBREW	23d. LOCATION (City or Town) BALTIMORE, MARYLAND	(County) MARYLAND	(State)
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	25a. REC'D BY REGISTRAR DATE OCT 31 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

Any delay is
1, 2, and 3 to
inform PM3 Page

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with page 3. File page 3 with your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 3 with Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: If necessary, please execute the certificate of death and return it to the funeral director. Page 4 should be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be retained for your files.

Health prior to burial, cremation

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b HOUR
<i>Mary</i>		<i>Sophie</i>	<i>Branigan</i>		<i>10-24-68</i>		<i>19</i>	<i>5:45PM</i>	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7f UNDER 1 YEAR MONTHS DAYS	7f UNDER 24 HRS HOURS MIN				
Female	W	5-30-81	87						
7b BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH				
<i>Maryland</i>		<i>U.S.A.</i>			<i>Baltimore Co.</i>				
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
<i>Rosedale</i>		<i>1247 Neighbors Ave.</i>			<i>Cleaning Woman</i>		<i>Hospital</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER				
<i>Nd.</i>		<i>Baltimore</i>	<i>Rosedale</i>	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<i>1247 Neighbors Ave.</i>				
14. FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME	First	Middle	Last	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT	ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
no		<i>213-18-1677</i>		<i>William H. Tudor</i>	<i>1247 Neighbors Ave.</i>				
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>ASHD</i>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DO TO, OR AS A CONSEQUENCE OF									
DO TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>17</i>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH:		21b TIME OF INJURY Month, Day, Year HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No.		City or Town	County	State	
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Theo C. Patterson</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>THEO C. PATTERSON</i>		ADDRESS (Street, city, town, or county)						22b DATE SIGNED <i>10/25/68</i>	
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE <i>10-28-68</i>		23c NAME OF CEMETERY OR CREMATORIAL <i>Zion Cemetery</i>		23d LOCATION (City or Town) <i>Baltimore Maryland</i>		(County) (State)	
24. FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR <i>OCT 28 1968</i>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
Philip E. Crach 1211 Chesaco Ave									



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

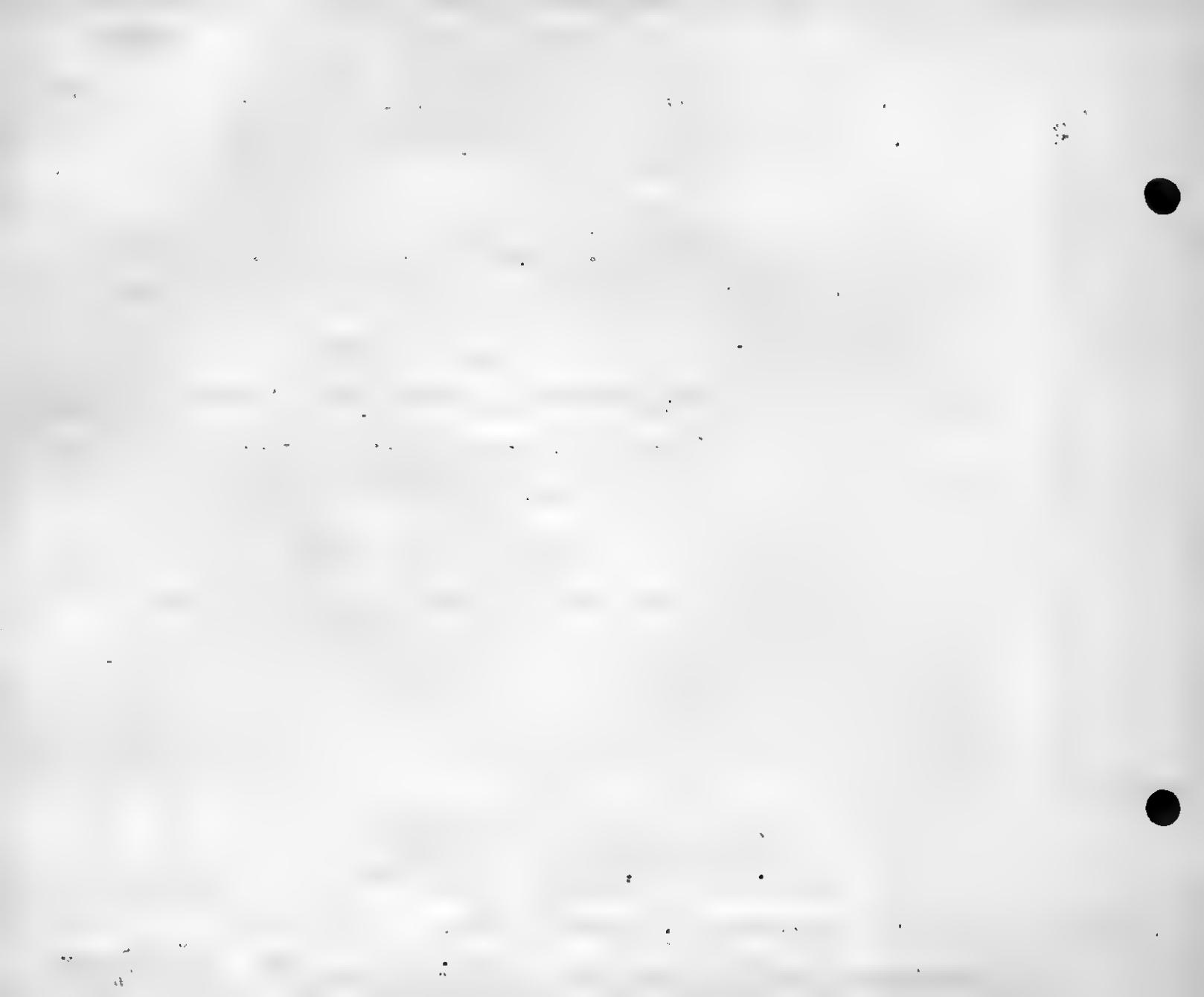
13936

CERTIFICATE OF DEATH

13947

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Robert	Middle Edward	Last Brathuhn, Sr.	2a. DATE OF DEATH Month 10	Day 10	Year 68	2b. HOUR 6:30P.M.			
3. SEX Male	4. RACE White	5. DATE OF BIRTH 7/27/23			6. AGE (In years last birthday) 45	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore				
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) D.O.A.-St. Josephs			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Police Sgt.			12b. KIND OF BUSINESS OR INDUSTRY Balto. City			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 4807 King Ave.						
14. FATHER'S NAME First Grover	Middle C.	Last Brathuhn	15. MOTHER'S MAIDEN NAME First Estelle	Middle	Last Clubb					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	16b. SOCIAL SECURITY NO. WWII	17. INFORMANT Leora Brathuhn	Address 4807 King Ave.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>				
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arterio sclerotic heart disease</u>						4 mos.				
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>7-28</u> , 19 <u>68</u> , to <u>10-10</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>10-10</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Wyman K. Wong, M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/>			MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 10/12/68			
22d. PHYSICIAN'S NAME (Type)		22e ADDRESS 6801 Belair Rd.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/14/68		23c. NAME OF CEMETERY OR CREMATORIAL Parkwood Cemetery		23d. LOCATION (City or Town) Baltimore		(County)	(State)	Maryland
24. FUNERAL DIRECTOR Robert C. Altenburg Funeral Home Inc. 6809 Harford Rd. - Balto., Md. 21214		ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles Judge			
					DATE OCT 15 1968					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13937

13948

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 & 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First CATHERINE	Middle A.	Last BREITENBACH	2a. DATE OF DEATH OCT Month 26 Doy 1968 Year	2b. HOUR 6:30 pm M
3. SEX F	4. RACE WHITE	S. DATE OF BIRTH APRIL 5, 1874	6 AGE (In years last birthday) 94 yrs.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS
7a. BIRTHPLACE (State or foreign country) GERMANY	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE		
10. CITY OR TOWN OF DEATH CATONSVILLE	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOOD NURSING HOME	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY		
13a. JUS/JAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND	13b. COUNTY BALTIMORE	13c. CITY OR TOWN LINTHICUM	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER FOREST VIEW ROAD	
14. FATHER'S NAME JOHANN MATTHIAS DEUTSCH	15. MOTHER'S MAIDEN NAME KATHRINA SCHAMANN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (or unknown) <input checked="" type="checkbox"/> (If yes give war or dates of service) No	16b. SOCIAL SECURITY NO. NONE	17. INFORMANT MAY NEIGHOFF	Address MD. 584 FOREST VIEW RD LINTHICUM		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Senility 440.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. 334 X (b) Arteriosclerosis Generalized DUE TO, OR AS A CONSEQUENCE OF (c)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Undetermined					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Stroke					
19a. MEDICAL CERTIFICATION DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (the hospital) attended the deceased from May 1956, 19, to October 26, 1968, that (I) (we) last saw the deceased alive on October 26, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Dr. A. Bradley Daugharty MD	22c. DATE SIGNED 10-28-68				
22d. PHYSICIAN'S NAME (Type) Dr. A. Bradley Daugharty	22e. ADDRESS 1264 Francis Avenue 21227				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 10-20-68	23c. NAME OF CEMETERY OR CREMATORIUM LOUDON PARK CEMETERY	23d. LOCATION (City or Town) BALTIMORE CITY, BALTIMORE MD.	(County)	(State)
24. FUNERAL DIRECTOR HOWARD H. HUBBARD	ADDRESS 4107 WILKENS AVE 21229	25a. REC'D BY REGISTRAR DATE OCT 31 1968	25b. REGISTRAR'S SIGNATURE j Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

13949

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. It should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

1. DECEASED NAME (Type or print)				First Helen	Middle Virginia	Last Bridgell	20. DATE OF DEATH Month October	Day 13 , 1968	2b HOUR 3 P.M.		
3. SEX F		4. RACE W		5. DATE OF BIRTH 12/8/1876		6. AGE (In years last birthday) 91 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Balto., Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore					
10. CITY OR TOWN OF DEATH Towson 21204		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Dulaney Towson N. H.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife				12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.		13b. COUNTY —		13c. CITY OR TOWN Balto. 21210		13d. INSIDE CITY & MTS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4403 Wickford Road			
14. FATHER'S NAME First William		Middle H.	Last Doste	15. MOTHER'S MAIDEN NAME First Mary		Middle C.	Last Start				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 215-01-1793		17. INFORMANT C. Orville Bridgell, (Same)		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis (Generalized) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
MEDICAL CERTIFICATION		19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —			
		21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) —					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.) —		21f. LOCATION Street or R.F.D. No. —		City or Town —		County —		State —	
22a. I certify that (I) (this hospital) attended the deceased from April 4, 1967 , to October 13, 1968 , that (I) (we) last saw the deceased alive on October 11, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Dr. Grafton W. Hersperger		22c. DEGREE —		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		22d. DATE SIGNED 10/14/68					
22d. PHYSICIAN'S NAME (Type) Dr. Grafton W. Hersperger		22e. ADDRESS Medical Arts Bldg.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/16/68		23c. NAME OF CEMETERY OR CREMATORIAL Druid Ridge		23d. LOCATION (City or Town) Pikesville, Balto., Co., Md.		(County) —		(State) —	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Rd. Balto. 12, Md.		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE —					
				DATE OCT 16 1968							



1393

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item#13b,c,e, Film#406 11/22/68 CERTIFICATE OF DEATH

13950

1. DECEASED NAME (Type or print)	First	Middle	Lost	2a. DATE OF DEATH Month Day Year	2b. HOUR
OSCAR		BRISCOE		10 22 68	4:20 AM
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (in years last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
MALR	CAU	02-28-78	90		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH		
Milling Co. Queenstown			Baltimore		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	
BALTO. MD.	GRTR. BALTO. MEDICAL CENTER			Md.	
13a. JEWISH RESIDENCE (Where deceased admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
Md.	Baltimore	Queenstown	Cockeysville	Milling Co., Masonic Homes	Middle
14. FATHER'S NAME	First	Middle	Lost	15. MOTHER'S MAIDEN NAME	Address
Vincent Briscoe				Hensuy	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT			
No	214 28 3074		Masonic Homes, Cockeysville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)	ACUTE RENAL FAILURE				1-2 DAYS
7410 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.	DUE TO, OR AS A CONSEQUENCE OF ACUTE MYOCARDIAL INFARCTION				5 HOURS
	DUE TO, OR AS A CONSEQUENCE OF DISSECTING ANEURYSM OF THE (AORTA, DIABETES MELLITIS WITH POSSIBLY FATTIC ACIDOSIS)				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
451X					
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from 10-08, 19 68, to 10-22, 19 68, that (I) (we) last saw the deceased alive on 10-22-68, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE	GIHAN TENNEKOON		ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>
22d. PHYSICIAN'S NAME (Type)	GIHAN TENNEKOON		22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL/SHIPMENT	23b. DATE Oct. 25, 68	23c. NAME OF CEMETERY OR CREMATORIUM Greenmount	23d. LOCATION (City or Town) Hillsboro, Caroline Co. Md.	(County)	(State)
24. FUNERAL DIRECTOR	ADDRESS		25a. REC'D BY REGISTRAR Wm. Cook-Brooks Towson, Towson, Md.	25b. REGISTRAR'S SIGNATURE	
VR A15 30M REV 4-68			OCT 23 1968		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13951

CERTIFICATE OF DEATH

13940

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First <u>Merril</u>	Middle <u>Augustus</u>	Last <u>Brooks</u>	2a. DATE OF DEATH Month <u>10</u>	Day <u>28</u>	Year <u>68</u>	2b. HOUR <u>2:30 P.M.</u>
3. SEX <u>Male</u>	4. RACE <u>White</u>	5. DATE OF BIRTH <u>8-30-89</u>			6. AGE (In years last birthday) <u>79</u>	IF UNDER 1 YEAR MONTHS <u>YRS.</u>	IF UNDER 24 MRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <u>Pa.</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <u>Baltimore</u>		
10. CITY OR TOWN OF DEATH <u>Baltimore</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Alto. County General</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Ket. Restaurant Prop.</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Pa. d.</u>		13b. COUNTY <u>Baltimore</u>	13c. CITY OR TOWN <u>Baltimore</u>	13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <u>65 Church Lane</u>	14. FATHER'S NAME First <u>John</u> Middle <u>J.</u> Last <u>Brooks</u>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>No</u>		16b. SOCIAL SECURITY NO <u>214-32-2966</u>	17. INFORMANT <u>Mr. Carl F. Brooks, 3718 Courtleigh Dr., Md.</u>	15. MOTHER'S MAIDEN NAME First <u>Elizabeth</u> Middle <u>--</u> Last <u>Barrett</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> 5/10 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute suppurative Pancreatitis</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myocardial infarct - IVS</u> AT LEAST MONTHS - PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>OLD myocardial infarct - IVS</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Simon Calle, MD</u>		DEGREE ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <u>10/27/68</u>		
22d. PHYSICIAN'S NAME (Type) <u>Simon Calle, M. D.</u>		22e. ADDRESS <u>Balto. Co. Gen'l Hosp. Randallstown, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10/30/68</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>SS. Peter & Paul Cem.</u>		23d. LOCATION (City or Town) <u>Cumberland, Allegany</u>	(County) <u>Md.</u>	(State)
24. FUNERAL DIRECTOR <u>H. Wayne George</u>		ADDRESS <u>Cumberland, Maryland</u>	25a. RECD BY REGISTRAR <u>DATE OCT 29 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR	
<i>Norman James Brosenner, Sr.</i>					OCT. 16	1968	8.30PM		
3. SEX		4 RACE	5. DATE OF BIRTH		6 AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
Male		white	12-29-1914		59 yrs.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore County		Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Mount Wilson		Mount Wilson State Hosp.			Landscaper				
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		RT. #3	
Md		Carroll		Town		Kees Mill Rd.		Sykesville	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
		Harry		Brosenner	Mary		E.	O'Neill	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT		Address			
No		219-10-6243		Records, Mt. Wilson State Hospital					
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))</p> <p>PART I. DEATH WAS CAUSED BY.</p> <p>IMMEDIATE CAUSE (a) <i>Carcinoma of lung</i></p> <p>16 DUE TO, OR AS A CONSEQUENCE OF</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b).</p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c)</p> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> <p>1.0 months</p>									
<p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)</p> <p>16b</p>									
MEDICAL CERTIFICATION		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
<p>22a. I certify that (I) (this hospital) attended the deceased from <u>8-24</u>, 19<u>68</u>, to <u>10-10</u>, 19<u>68</u>, that (I) (we) last saw the deceased alive on <u>Oct. 10</u>, 19<u>68</u>, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</p>									
22b. SIGNATURE		<i>William Newcomer</i>		DEGREE	ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED		<u>10-10-68</u>	
22d. PHYSICIAN'S NAME (Type)		William Newcomer, M.D.		22e. ADDRESS		Mount Wilson, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City or Town)		(County)	(State)
Burial		10/15/1968		Lakeview Mem. Gardens		Carroll, Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
C. M. Waltz, Box 241, Sykesville, Md.				DATE OCT 15 1968		<i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

13942

13953

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First CHARLES	Middle H.	Last BROWN	2a. DATE OF DEATH Month 10	Doy 17	Year 68	2b. HOUR 3:05AM			
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 6/29/95			6. AGE (In years last birthday) 73	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. MONTHS 0	IF UNDER 24 HRS. DAYS 0	MIN 0	
7a BIRTHPLACE (State or foreign country) MARYLAND	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE COUNTY, Md							
10. CITY OR TOWN OF DEATH FORT HOWARD	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital or street address) VET. ADM. HOSPITAL			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) SHOE SALESMAN			12b. KIND OF BUSINESS OR INDUSTRY SHOE COMPANY			
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE MARYLAND	13b COUNTY Baltimore	13c. CITY OR TOWN BALTIMORE	13d INSIDE CTY JMDTS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 616 Cooks Lane						
14. FATHER'S NAME First WILLIAM H. BROWN	Middle	Last	15. MOTHER'S MAIDEN NAME First SARA	Middle	Last CAMPBELL					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, unknown YES	16b. SOCIAL SECURITY NO. (If yes answer in boxes of service) WW 1 212 01 36 32	17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.	Address							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last BRONCHOPNEUMONIA,								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 DAY		
(b) PULMONARY EMPHYSEMA, MARKED								YEARS		
(c) ARTERIOSCLEROSIS MARKED, GENERALIZED								OLD		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) BENIGN PROSTATIC HYPERTROPHY, OLD. ENCEPHALOMALACIA, LEFT CEREBRUM, OLD										
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES				
<input type="checkbox"/> ACCIDENT WAS UNDERLYING <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.	City or Town		County	State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 6/26/68 , 19_____, to 10/17/68 , 19_____, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10/17/68 , 19_____, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (did not) view the body after death.										
22b. SIGNATURE <i>Peter Juvan</i>		DEGREE M.D.	ATTENDING PHYS. <input type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED 10/17/68				
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS VAH FORT HOWARD, MARYLAND								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 10/21/68	23c. NAME OF CEMETERY OR CREMATORIAL BALTIMORE NATIONAL			23d. LOCATION (City or Town) BALTIMORE, MARYLAND		(County) Maryland	(State) Md	
24. FUNERAL DIRECTOR		ADDRESS WITZKE FUNERAL HOME 4101 EDMONDSON AVENUE, BALTIMORE, MD.			25a. REG'D BY REGISTRAR 007	25b. REGISTRAR'S SIGNATURE <i>Frank J. Judge</i>				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13954

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1, 2 and 3 from this certificate and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First NEHLIE	Middle D	Lost Brown	2a. DATE OF DEATH Month 10	Day 6	Year 68	2b. HOUR 7A M	
3 SEX F.	4 RACE NEGRO	5. DATE OF BIRTH 4/2/83		6. AGE (in years last birthday) 85 yrs		7. IF UNDER 1 YEAR MONTHS 85	8. IF UNDER 24 HRS HOURS 7A M	
7a. BIRTHPLACE (State or foreign country) MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH BALTO.					
10 CITY OR TOWN OF DEATH Towson	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 421 E. PA. AVE.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY House			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE MD	13b. COUNTY BALTO	13c. CITY OR TOWN Towson	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER 421 E. PA. AVE.				
14 FATHER'S NAME John	First John	Middle Clinton	15 MOTHER'S MAIDEN NAME First Elizabeth	Middle Morgan	Address Margaret Brown 421 E. Pa. Ave.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. none	17 INFORMANT Margaret Brown	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. _____ 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory or office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (the hospital) attended the deceased from 3/15/56 , 19 56 , to 10/6/68 , 19 68 , that (I) (we) last saw the deceased alive on 9/25/68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE T. C. Siwinski		DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED Oct. 7, 1968		
22d. PHYSICIAN'S NAME (Type) T. C. Siwinski, M.D.		22e. ADDRESS 206 W. Pennsylvania Ave., Towson, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 10/9/68	23c. NAME OF CEMETERY OR CREMATORIAL John Wesley		23d. LOCATION (City or Town) (County) Arlington (Md.)			(State)
24. FUNERAL DIRECTOR Am. L. Chatman		ADDRESS 1701 W. Gellot St.	25a. RECD BY REGISTRAR OCT 10 1968		25b. REGISTRAR'S SIGNATURE Charles J. Judge			



13846

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13955

EVELYN

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month / Day / Year	2b HOUR 6 30 AM
<i>Evelyn</i>			—	Buell	October 13 1968	
3. SEX FEMALE		4 RACE White	5 DATE OF BIRTH 8-14-1895	6 AGE (in years last birthday) 73 YRS	IF UNDER 1 YEAR MONTHS	IF JUNIOR 24 HRS. HOURS MIN
7a BIRTHPLACE (State or foreign country) Baltimore, Md.		7b CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Baltimore County		
10 CITY OR TOWN OF DEATH Towson		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Ches. Anor Nurs. Home		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Presser	12b KIND OF BUSINESS OR INDUSTRY Clothing	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland		13c CITY OR TOWN Baltimore Co.	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 1699 Kirkwood Rd. 21207		
14. FATHER'S NAME First No		Middle Belt	Last	15. MOTHER'S MAIDEN NAME First Rachel	Middle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO 220-05-3708	17 INFORMANT T. Richard Buell, 1699 Kirkwood Rd.	Address		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		<i>Pulmonary Embolism</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Immediately</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Perforated Left Blew with last.		DUE TO, OR AS A CONSEQUENCE OF <i>Perforated Left Blew with Surgery.</i>				<i>2 1/2 Mos</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 5411						
19a. DATE OF OPERATION 8/1/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Perforated Left Blew	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from July 30, 1968 , to October 13 1968 , that (I) (we) last saw the deceased alive on October 6 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>W. Grafton Hersperger</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 10/14/68			
22d. PHYSICIAN'S NAME (Type) W. Grafton Hersperger		22e. ADDRESS 214 Medical Arts Bld.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct. 16, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Lakeview Cemetery	23d. LOCATION (City or Town) Carroll County, Md.	(County)	(State)
24. FUNERAL DIRECTOR Vitzke Fun. Dir., 4101 Edmondson Ave.		ADDRESS		25a. REC'D BY REGISTRAR OCT 15 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Juges</i>	
VR A15 30M REV 1		DATE				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First WILLIAM	Middle RICHARD	Last BUERHAUS	2a. DATE OF DEATH Month 10	Day 18	Year 68	2b. HOUR 1:45 PM
3. SEX male	4 RACE WHITE	5. DATE OF BIRTH 9/1/14			6. AGE (In years last birthday) 54	IF UNDER MONTHS YRS.	IF UNDER 24 HRS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE,				
10. CITY OR TOWN OF DEATH FORT HOWARD	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital street address) VET. AM. HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) TRUCK DRIVER			12b. KIND OF BUSINESS OR INDUSTRY BREWERY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) MARYLAND	13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES	13e. STREET AND NUMBER 1002 FOXCHASE LANE			
14. FATHER'S NAME First FREDERICK	Middle BUERHAUS	Last	15. MOTHER'S MAIDEN NAME First PEARL	Middle	Last MYERS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES	16b. SOCIAL SECURITY NO. (If you give war service dates of service) WW 11 217 03 78 96	17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.	Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RESPIRATORY INSUFFICIENCY 14 10 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause LEFT BRONCHOPNEUMONIA, UNKNOWN ORGANISM (b) DUE TO, OR AS A CONSEQUENCE OF PULMONARY EMPHYSEMA AND FIBROSIS (c) DUE TO, OR AS A CONSEQUENCE OF HEALED MILITARY TUBERCULOSIS. POST OPERATIVE RIGHT LOWER LOBECTOMY						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) HEALED MILITARY TUBERCULOSIS. POST OPERATIVE RIGHT LOWER LOBECTOMY							
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med'col examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that 10 (this hospital) attended the deceased from 10/16/68 , 19 19 , to 10/18/68 , 19 19 , that (I) (we) lost saw the deceased alive on 10/18/68 , 19 19 , and that in (I) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Neilson Neilson, M.D.</i>		DEGREE ATTENDING PHYS.	<input type="checkbox"/>	MED. DIRECTOR	<input type="checkbox"/>	STAFF PHYS.	22c. DATE SIGNED 10/18/68
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS VAH FORT HOWARD, MARYLAND					
23a. BURIAL, CREMATION, BURIAL (Specify)		23b. DATE 10/21/68	23c. NAME OF CEMETERY OR CREMATORIAL BALTIMORE NATIONAL		23d. LOCATION (City or Town) BALTIMORE, MARYLAND	(County) BALTIMORE, MARYLAND	(State) MARYLAND
24. FUNERAL DIRECTOR <i>Zannino Funeral Home</i>		ADDRESS 257 S. Cocking St. Baltimore, Md.	25a. DATE BY REGISTRAR OCT 21 1968		25b. REGISTRAR'S SIGNATURE <i>John J. Zannino</i>		
VR AT&T 30M RE 108							



13346

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

13957

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon papers. **Page 3** should be detached for use as the burial-transit permit. Then please remove carbon papers. **Page 2** should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Herbert	Middle H	Last BURGESS	20. DATE OF DEATH Month 10	Day 31	Year 1968	2b. HOUR 11:55 A.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH 10/25/1901			6. AGE (In years last birthday) 67 yrs.		
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	9. COUNTY OF DEATH Baltimore,	If Under 24 Hrs. MONTHS DAYS HOURS MIN.			
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) ENGINEER			12b. KIND OF BUSINESS OR INDUSTRY BASIC RECO		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 8401 Avery Rd.			
14. FATHER'S NAME First HARRY	Middle BURGESS	Last	15. MOTHER'S MAIDEN NAME First MARGARET TAYLOR	Middle	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes, no, or unknown CAR	16b. SOCIAL SECURITY NO. 217-03-7508	17. INFORMANT CATHERINE BURGESS	Address 8401 Avery				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor pulmonale secondary to 17X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause diffuse chronic pulmonary fibrosis DUE TO, OR AS A CONSEQUENCE OF (b) diffuse chronic pulmonary fibrosis DUE TO, OR AS A CONSEQUENCE OF (c)							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from 10/30/68 , to 10/31/68 , that (I) (we) last saw the deceased alive on 10/31/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE Lilia C. Baldonado		DEGREE M.D.	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input checked="" type="checkbox"/>	22c. DATE SIGNED 10/31/68	
22d. PHYSICIAN'S NAME (Type) Lilia C. Baldonado, M.D.		22e. ADDRESS 7620 York Rd., Towson, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 11/4/68	23c. NAME OF CEMETERY OR CREMATORIAL NEW CATHEDRAL			23d. LOCATION (City or Town) BALTIMORE, MD.	(County)	(State)
24. FUNERAL DIRECTOR J. G. CONNELLY SEAS	ADDRESS 300 NACE				25a. REC'D BY REGISTRAR NOV 4 1968	25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

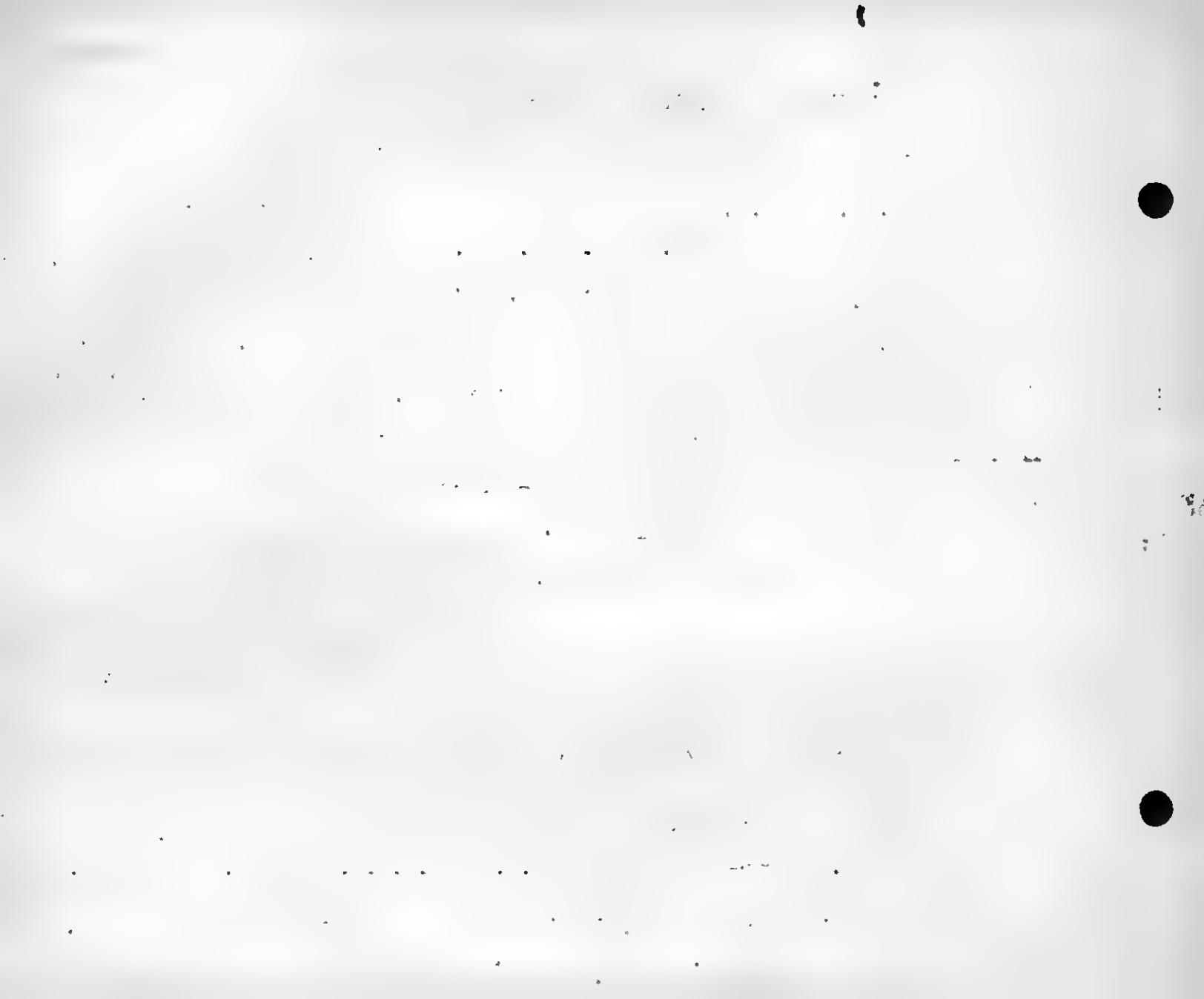
CERTIFICATE OF DEATH

13958

13947

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
11 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. If any remains, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First Virginia	Middle Morrow	Lost Burnham	2a. DATE OF DEATH 10 Month 6 Day 68 Year	2b. HOUR 5 40 a.m.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 2/28/1898	6. AGE (In years last birthday) 70 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Balto., Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH Baltimore County		
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital or street address) Great. Balt. Med. Cen.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 4 Upland Road		
14. FATHER'S NAME First Charles		Middle A.	Lost Morrow	15. MOTHER'S MAIDEN NAME First Maude		Middle E.	Lost Bellis
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 213-28-2077		17. INFORMANT George H. Burnham		Address Towson, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest Failure							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs							
DUE TO, OR AS A CONSEQUENCE OF Con Pulmonale*- Severe							
(b) DUE TO, OR AS A CONSEQUENCE OF stating the underlying cause Chronic Emphysema							
12 yrs							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Coronary insufficiency							
19a. MEDICAL CERTIFICATION 5371		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10/4/68 to 10/6/68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10/4/68 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (did not) view the body after death.							
22b. SIGNATURE Dr. S. G. Maghami		DEGREE ATTENDING PHYS.	22c. DATE SIGNED 10/6/68	MED. DIRECTOR	STAFF PHYS.		
22d. PHYSICIAN'S NAME (Type) Dr. Shirin-Ghaem Maghami M.D.		22e. ADDRESS G.B.M.C. 6701 N. Charles St.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/8/68	23c. NAME OF CEMETERY OR CREMATORIAL St. Ann's		23d. LOCATION (City or Town) Annapolis		(County) Md.
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 14905 York Rd. Balto., Md.	25a. REC'D BY REGISTRAR OCT 8 1968		25b. REGISTRAR'S SIGNATURE J Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is to be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13959

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. LENGTH OF STAY IN 1b 44 Croftley Road		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 44 Croftley Road		d. STREET ADDRESS 44 Croftley Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Name	Middle Florence	Last Burns	4. DATE OF DEATH October 14, 1968	Month Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 25, 1879	9. AGE (in years) IF UNDER 1 YEAR 89 yrs.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME John R. Sparks		14. MOTHER'S MAIDEN NAME Mary Ann Grey		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. None	17. INFORMANT Family records	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTIONS (multiple) INTERVAL BETWEEN ONSET AND DEATH 1 MINUTE					
4 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Heart Disease YEARS					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 4					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Towson	(County) (State) MD
21. I certify that (I) (this hospital) attended the deceased from 8/14 , 19 60 , to 10/14 , 19 68 , that (I) (we) last saw the deceased alive on 10/11 , 19 68 , and that death occurred at 9:50 AM, from the causes and on the date stated above.					
22a. SIGNATURE Donald L. Somerville					
22b. DATE SIGNED 10/15/68					
22c. PHYSICIAN'S NAME (Type) Donald L. Somerville		22d. ADDRESS Towson, MD 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 16, 1968	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Prospect Hill Cemetery	23d. LOCATION (City, town or county) (State) Towson, Maryland	
24. FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland		ADDRESS	25a. DATE OCT 17 1968	25b. REGISTRAR'S SIGNATURE Charles Judge	25c. REGISTRAR'S SIGNATURE



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13960

1. DECEASED NAME (Type or print) Frank BABY Joseph			Middle BOY	Last BUSSEY	2a. DATE OF DEATH Month 10 Day 30 Year 68	2b. HOUR 12:28 AM
3. SEX M.	4. RACE White	5. DATE OF BIRTH 10/29/68			6. AGE (in years last birthday) YRS. 6	IF JUNIOR 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Towson	7b. CITIZEN OF WHAT COUNTRY? Greater BALTO., MED. CEN.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH BALTO., MD.			
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital Greater BALTO., MED. CEN.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Holiday Estates Lot A 30		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland	13b. COUNTY Anne Arundel	13c. CITY OR TOWN Jessup	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER Holiday Estates Lot A 30		
14. FATHER'S NAME Francis Milton Bussey	15. MOTHER'S MAIDEN NAME Garnette Sue Jenkins					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes	16b. SOCIAL SECURITY NO. If yes give war or dates of service	17. INFORMANT			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause RESPIRATORY DISEASE (b) DUE TO, OR AS A CONSEQUENCE OF HYALINE MEMBRANE DISEASE (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) PREMATURE						
19a. DATE OF OPERATION 10/29/68	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. 10 Month Day Year P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) 19				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. G.B.M.C.	City or Town G.B.M.C.	County Baltimore	State Maryland	
22a. I certify that (I) (this hospital) attended the deceased from 10/30/68 , to 10/30/68 , that (I) (we) last saw the deceased alive on 10/30/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE A. Finkel			DEGREE ATTENDING PHYS.	22c. DATE SIGNED 10/30/68	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22d. PHYSICIAN'S NAME (Type) A. FINKEL	22e. ADDRESS G.B.M.C.					
23a. BURIAL, CREMATION, (Specify) CREMATION	23b. DATE 10/30/68	23c. NAME OF CEMETERY OR CREMATORIAL G.B.M.C.	23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR R. Finkel	ADDRESS 101 W. ST. LUCILLE	25a. REC'D BY REGISTRAR DATE NOV 6 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

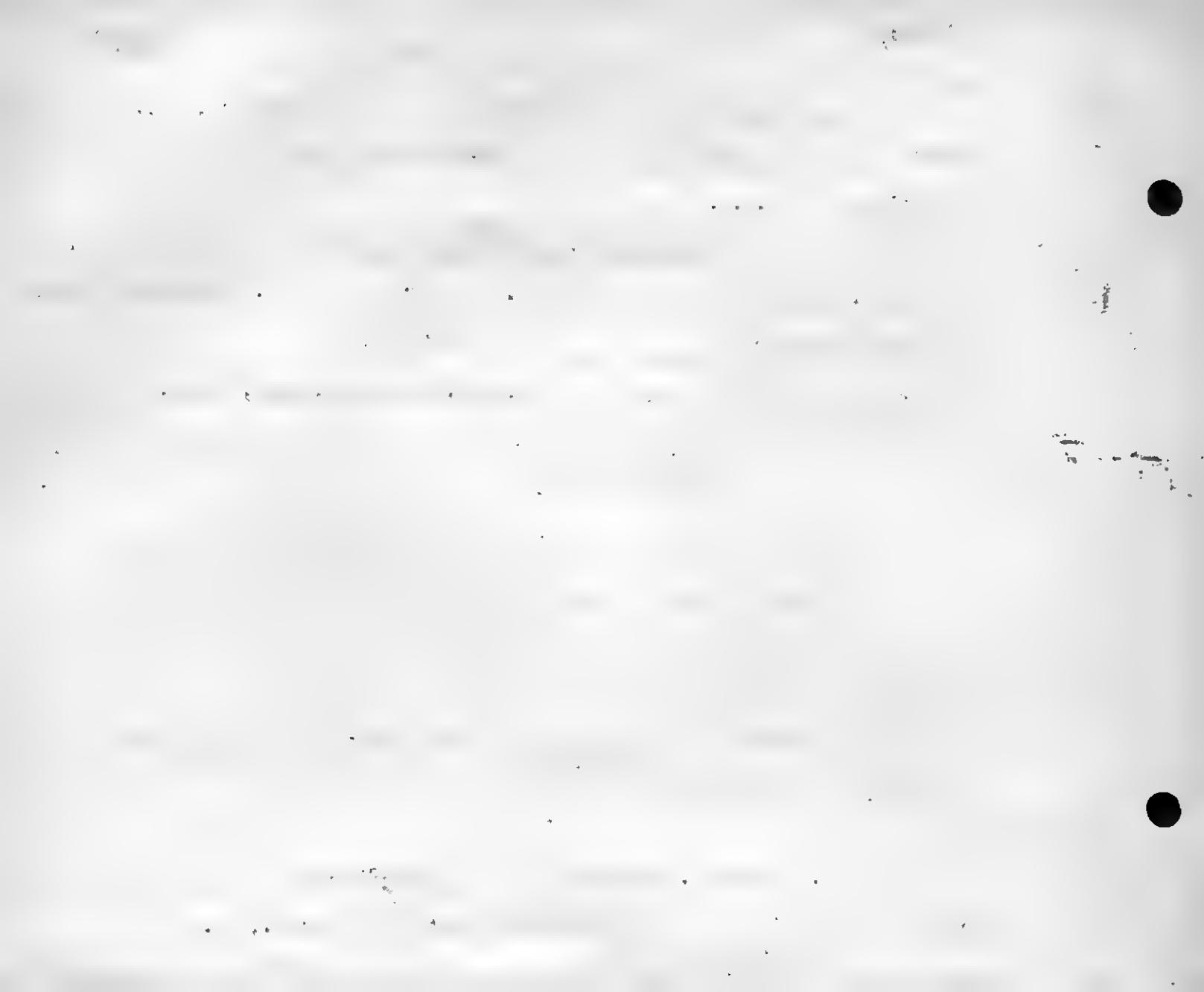
13950

13961

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician's director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR 9pm
Mary (Marie)		Butcher		October 7, 1968	
3. SEX female	4. RACE white	5. DATE OF BIRTH September 28, 1896		6. AGE (In years last birthday) 72 yrs	F UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Baltimore	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Baltimore	12b. KIND OF BUSINESS OR INDUSTRY at home	
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Chesapeake Manor Nursing		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	
13c. CITY OR TOWN Balto.	13d. INSIDE CITY, JM TSP? YES <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 430 N. Rose Street 21224	14. FATHER'S NAME First Middle Last James Machovc		
15. MOTHER'S MAIDEN NAME First Middle Last Marie ?	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? (If yes give war or dates of service) no		16b. SOCIAL SECURITY NO. none	17. INFORMANT Agnes M. Posluszny, dht., above.	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Carcinoma 6 wks. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 11/68 (b) Carcinoma of Retroperitoneal lymph 6 months DUE TO, OR AS A CONSEQUENCE OF (c) lymph 6 months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from 9/23, 1968 , to 10/7, 1968 , that (I) (we) last saw the deceased alive on 10/6, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Charles F. O'Donnell		DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 10/7/68
22d. PHYSICIAN'S NAME (Type) Dr. Charles F. O'Donnell		22e. ADDRESS 7501 York Road			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/9/68	23c. NAME OF CEMETERY OR CREMATORIAL Holy Redeemer Cemetery		23d. LOCATION (City or Town) Balto., Md.	(County) (State)
24. FUNERAL DIRECTOR Schimunek Funeral Home	ADDRESS 3331 Brehms Lane 21213	25a. REC'D BY REGISTRAR DATE OCT 9 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



13962

CERTIFICATE OF DEATH

13951

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be certified within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. If any event, within 72 hours of death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR Hour Min M.M.
3 SEX	4. RACE	5. DATE OF BIRTH		6. AGE (in years last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	10d. KIND OF BUSINESS OR INDUSTRY
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. STREET AND NUMBER
13a. US/JAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	Address
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	16b. SOCIAL SECURITY NO.	17. INFORMANT			
Summit Nursing Home Records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute massive myocardial infarction</u>					
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>4109</u>					
(b) <u>Pulmonary fibrosis</u>					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
4201					
19a. MEDICAL CERTIFICATION	19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)	21b. TIME OF INJURY Hour AM Month Day Year P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) 19			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 29</u> , 19 <u>68</u> , to <u>Oct 31</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>Oct 29</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Stanley Ankudas, M.D. <i>Stanley Ankudas</i> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> DATE SIGNED 10/30/68					
22c. PHYSICIAN'S NAME (Type)	22e ADDRESS 1101 Linden Choice Lane				
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 11-1-68	23c. NAME OF CEMETERY OR CREMATORIAL Facility <i>Summit Cemetery</i>	23d. LOCATION (City or Town) Richardson	(County)	(State)
24. FUNERAL DIRECTOR	ADDRESS <i>Charles Miller Inc-715 Baltimore St. Baltimore</i>	25a. REC'D BY REGISTRAR DATE OCT 31 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13963

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the attending physician or attending physician. Page 4 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13952

1. DECEASED NAME (Type or print)	First William	Middle	Last CALVERT	20. DATE OF DEATH Month 10	Day 16	Year 1968	2b. HOUR A.M. 9:20
3. SEX Male	4 RACE White	S. DATE OF BIRTH July 27, 1921	6. AGE (In years lost birthday) 47 yrs.	IF UNDER MONTHS	YEAR DAYS	F. UNDER 24 HRS. HOURS	
7a. BIRTHPLACE (State or foreign country) South Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore,	12b. KIND OF BUSINESS OR INDUSTRY City of Balto			
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. JOSEPH HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Carpenter					
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland	13b. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 14½ Elmont Ave.				
14. FATHER'S NAME John Earl Calvert	15. MOTHER'S MAIDEN NAME Hattie	Middle	Last Nicholas				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes	16b. SOCIAL SECURITY NO. W.W.11	17. INFORMANT Mrs Lillian Calvert 11½ Elmont Avenue	Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hepatic Coma DUE TO, OR AS A CONSEQUENCE OF (b) Secondary to Portal Cirrhosis and DUE TO, OR AS A CONSEQUENCE OF (c) Massive Gastro-Intestinal Bleeding.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION 10/9		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Bleeding peptic ulcer	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10/9/1968 to 10/16/1968, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10/16/1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Christian Feliciano		DEGREE	ATTENDING PHYS.	MED DIRECTOR	STAFF PHYS.	22c. DATE SIGNED 10/16/68	
22d. PHYSICIAN'S NAME (Type) Christiana Feliciano, M.D.		22e. ADDRESS 7620 York Rd., Towson, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10-19-1968	23c. NAME OF CEMETERY OR CREMATORIUM Gardens of Faith Cemetery	23d. LOCATION (City or Town) Baltimore	(County) Co.	(State) Md.		
24. FUNERAL DIRECTOR Assahn Funeral Home 7401 Belair Road 21236			ADDRESS	25a. RECD. BY REGISTRAR OCT 21 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH

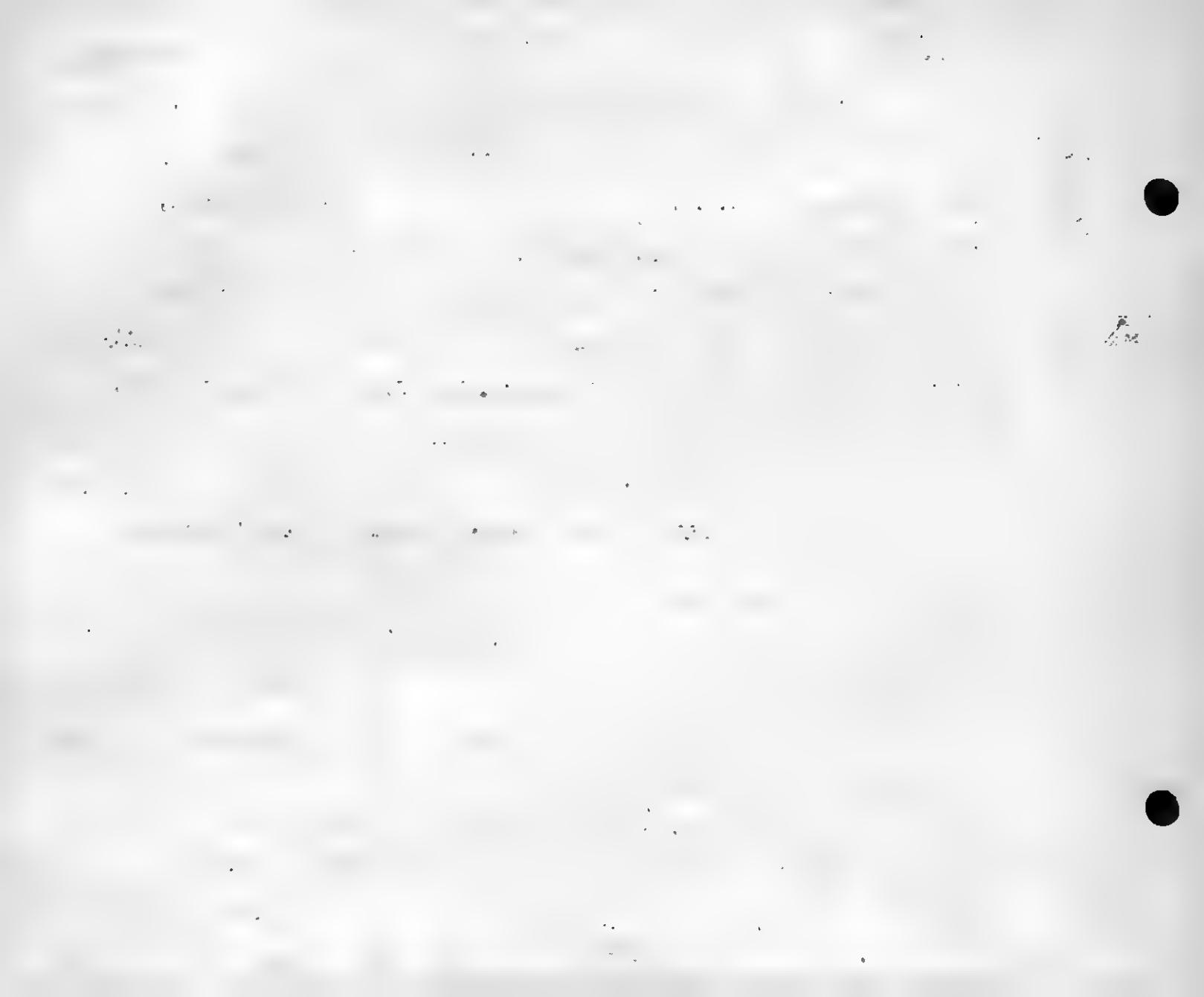
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 6 FilmGIC6 10/17/68

CERTIFICATE OF DEATH

13964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event.

1. DECEASED-NAME (Type or print)	First OLIE	Middle MARION	Last CARPENTER	2d. DATE OF DEATH Month 10	2b. HOUR Hour 1:00A M	
3. SEX MALE	4 RACE WHITE	5. DATE OF BIRTH 11/18/93		6. AGE (In years lost birthday) 75 74 yrs.	F UNDER 1 YEAR MONTHS 75	IF UNDER 24 HRS DAYS 74
7a. BIRTHPLACE (State or foreign country) EASTON, MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE COUNTY,		
10. CITY OR TOWN OF DEATH FORT HOWARD	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital or via street address) VET. ADM. HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) WATERMAN		12b. KIND OF BUSINESS OR INDUSTRY FLEETWOOD		
13a. US/JAL RESIDENCE (Where deceased lived, if institution admission) STATE MARYLAND	13b. CITY OR TOWN TALBOT COUNTY	13c. CITY OR TOWN EASTON	13d. INSIDE CTY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Rt 3, Box 29		
14. FATHER'S NAME First CHARLES	Middle W.	Last CARPENTER	15. MOTHER'S MAIDEN NAME First LUCY	Middle 	Last FLEETWOOD	
16a. WAS DECEASED EVER Yes, no, or unknown YES	In U.S. ARMED FORCES? WW I	16b. SOCIAL SECURITY NO 218 01 69 22	17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.	Address APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> BRONCHOPNEUMONIA, TERMINAL						
DUE TO, OR AS A CONSEQUENCE OF (b) MULTIPLE MYELOMA						
DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC RENAL FAILURE SECONDARY TO MULTIPLE MYELOMA						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO AUTOPSY	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from 9/16/68 , 19____, to 10/17/68 , 19____, that (I) (we) last saw the deceased alive on 10/17/68 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (He) (she) (we) did not view the body after death.						
22b. SIGNATURE <i>Reverin</i>		DEGREE RODOLFO G. MIRO, M. D.	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED 10/17/68
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS VAH FORT HOWARD, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 10/19/68	23c. NAME OF CEMETERY OR CREMATORIAL Fairview Cemetery	23d. LOCATION (City or Town) EASTON, MARYLAND	(County)	(State)
24. FUNERAL DIRECTOR <i>J. Heverin</i>		ADDRESS REAVISON FUNERAL HOME	25a. REC'D BY REGISTRAR DATE OCT 21 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
VR A15 30M REV						



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13965

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR AM PM	
<i>John T. CARROLL</i>					OCT 12 1968	11 45 P.M.	
3. SEX		4. RACE		S. DATE OF BIRTH	6. AGE (in years last birthday) MONTHS DAYS		
M		CAU		JUNE 12, 1875 93 YRS	IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (State or foreign country) <i>CANANDAIGUA, N.Y.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>BALTO.</i>		
10. CITY OR TOWN OF DEATH <i>TOWSON</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>DULANEY TOWSON N.H.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>BY-R.R.</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>RAILROAD</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>		13b. COUNTY <i>BALTO.</i>		13c. CITY OR TOWN <i>BALTO.</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>CAMBRIDGE ARMS APTS. CHARLES ST.</i>	
14. FATHER'S NAME First		Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last	
<i>JAMES</i>		-	<i>CARROLL</i>	<i>ELLEN O'BRIEN</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO. <i>220-44-9394</i>		17. INFORMANT <i>JOHN G. CARROLL Rd #1 OXFORD, Md.</i>	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Atherosclerotic Cardio-Vascular Disease</i>					APPROXIMATE INTERVAL BETWEEN DISEASE AND DEATH <i>10 yrs</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4/1</i>		<i>Broncho-pneumonia</i>					1 week
(b)							
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from <u>10-10</u> , 19 <u>68</u> , to <u>10-12</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>10-11</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Philip J. Flynn</i>		40	DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>10-14-68</i>	
22d. PHYSICIAN'S NAME (Type) <i>Philip J. Flynn</i>		40	22e. ADDRESS <i>11 E. Chase St.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>10/15/68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Newfoundland</i>		23d. LOCATION (City or Town) <i>Baltimore, Md.</i>	(County)	(State)
24. FUNERAL DIRECTOR <i>Wm. Cook-Brooks Towson, 1550 York Rd., Towson, Md.</i>		ADDRESS	25a. REC'D BY REGISTRAR <i>DATE OCT 15 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13966

Item#13d

File # 06 11/22 CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician,
director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2
should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

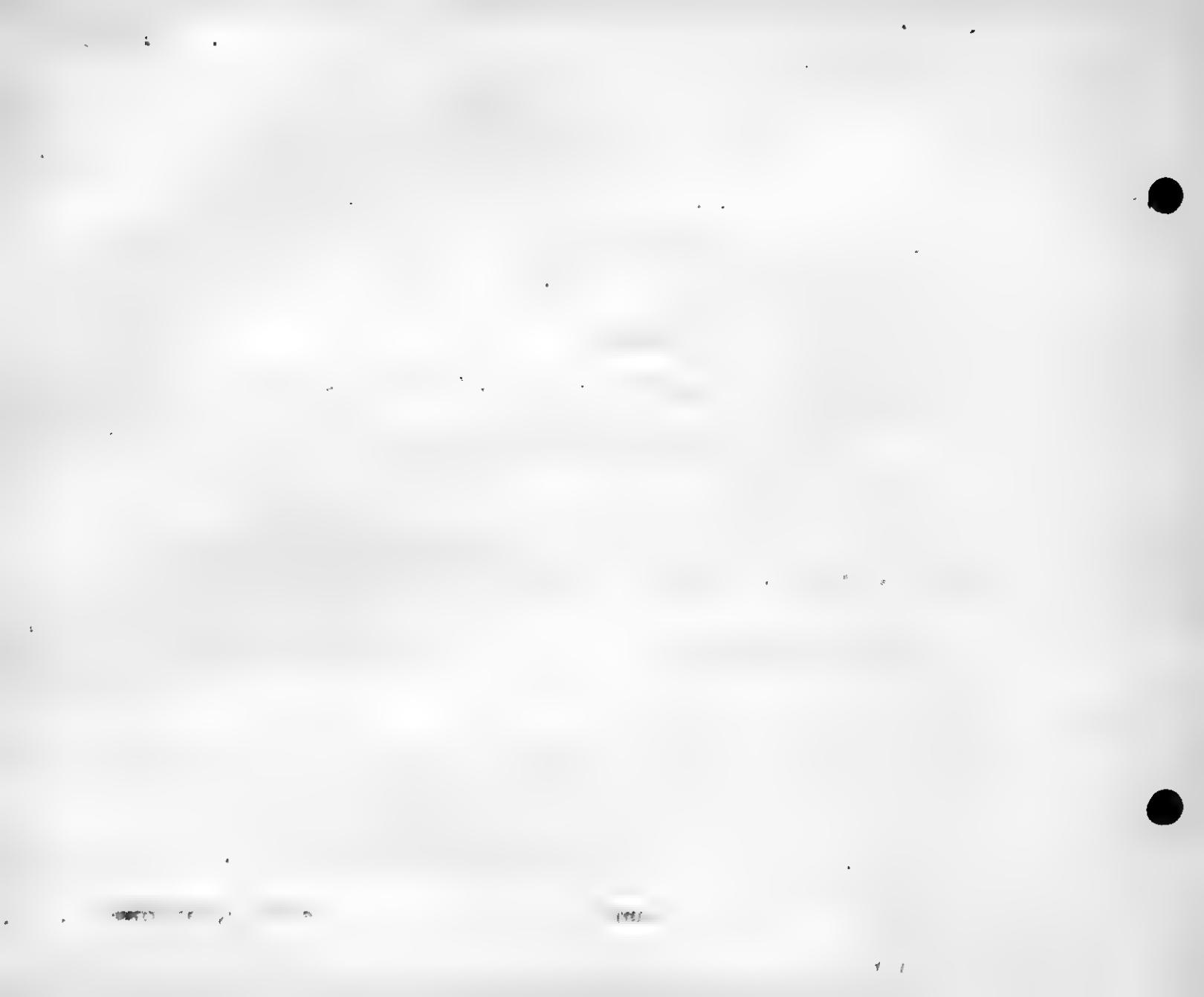
1	13953	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										13966
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print)			First	Middle	Lost	2. DATE OF DEATH			2b. HOUR			
Florence			M.	Cecil		10	10	68	Year	1:45am		
3. SEX		4 RACE			5 DATE OF BIRTH			6 AGE (In years lost birthday) 78 yrs.				
Female		Caucasian			10-19-89			IF UNDER 24 HRS. MONTHS DAYS HOURS MIN				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Baltimore				
Md.		U.S.A.										
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY				
Towson, Maryland		Greater Balto. Med. Cent			Towson			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	615 Chestnut Ave.			
14 FATHER'S NAME		First	Middle	Lost	15 MOTHER'S MAIDEN NAME			First	Middle	Lost		
		John	M.	Cecil				Mary M.	Grassley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.			17. INFORMANT			Address				
		217-05-4297A			Pickersgill, Same as # 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART I. DEATH WAS CAUSED BY.												
IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u>												
4129 DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 4221 (b) <u>Arterial sclerosis cardio vascular disease.</u>												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
Chronic necrotic cystitis												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
10-9-68		Pelvic mass r/o malign.			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.			City or Town	County	State		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9-11, 19 68 to 10-10, 19 68, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10-10 1968, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> did not view the body after death.												
22b. SIGNATURE <u>Chassem Pour Adib</u>		DEGREE	ATTENDING PHYS.	<input type="checkbox"/>	MED DIRECTOR	<input type="checkbox"/>	STAFF PHYS.	<input checked="" type="checkbox"/>	22c. DATE SIGNED 10-10-68			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS GBMC 6701 N. Charles St.										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-12-1968		23c. NAME OF CEMETERY OR CREMATORIUM Woodlawn			23d. LOCATION (City or Town) Woodlawn, Md.		(County)	(State)		
24. FUNERAL DIRECTOR W.M. Cook-Brooks Towson, 1050 York Rd. 22204		ADDRESS			25a. REC'D. BY REGISTRAR OCT 14 1968			26. REGISTERED SIGNATURE <u>Judge</u>				
VR A15 30M REV												



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH												13967		
1. DECEASED NAME (Type or Print)			First	Middle	Lost	20. DATE KNOWN OF ESTI- DEATH MATED			Month	Day	Year	2b HOUR		
			LEWIS	J.	CHEEK	<input checked="" type="checkbox"/> 10/31/68			19			6:00AM		
3 SEX	4 RACE	S DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	2c. DATE PRONOUNCED DEAD			2d HOUR					
MALE	WHITE	12/3/13	54	MONTHS	DAYS	HOURS	MIN	Month	Day	Year				
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. COUNTY OF DEATH					
NORTH CAROLINA			U.S.A.			WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			BALTIMORE COUNTY,			Md.		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR IND. STRY					
FT. HOWARD			VA HOSPITAL			CARPENTER'S HELPER			CONSTRUCTION					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. MS CITY, MTS?			13e STREET AND NUMBER		
MARYLAND			HARFORD			STREET			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
14 FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First	Middle	Lost			
			JOSEPH		CHEEK	MYRTLE					JENNINGS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS					
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			212 14 05 69			CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HYPERTENSIVE CARDIOVASCULAR DISEASE WITH COR PULMONALE												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
1120 DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a). storing the underlying cause last. 443X (b) _____ DUE TO, OR AS A CONSEQUENCE OF														
(c) _____														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CHRONIC ALCOHOLISM. PULMONARY EMPHYSEMA														
19a. MEDICAL CERTIFICATION DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?								
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) Now			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town			County	State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												22b. DATE SIGNED 10/31/68		
ACTUAL SIGNATURE <i>M.B. Davis</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			MD ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			ADDRESS (Street, City, Town, or County) MELVIN B. DAVIS, M. D., 6800 MORNIN GTON RD., BALTIMORE, MD. 21222		
23a. BURIAL CREATON, REMOVAL (Specify) BURIAL			23b. DATE 11/2/68			23c. NAME OF CEMETERY OR CREMATORIY Mount Zion Cemetery			23d. LOCATION (City or Town) Bel Air; Harford Co., Md.			(County) (State)		
24. FUNERAL DIRECTOR JOHN H. HARKINS			ADDRESS Harkins Funeral Home Delta, Pennsylvania			25a. REC'D BY REGISTRAR NOV 6 1968			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					
VR A15ME (5) 10M REV. 7/68														



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13968

13957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)	First VINCENT	Middle L.	Last CILISHAM	2a. DATE OF DEATH Month October	Day 18,	Year 1968.	2b. HOUR 5 PM			
3. SEX Male	4. RACE White	5. DATE OF BIRTH October 18, 1895.		6. AGE (In years last birthday) 73	IF UNDER MONTHS 0	YEAR DAYS 0	IF UNDER 24 HRS. HOURS 0	MIN. 0		
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore,						
10. CITY OR TOWN OF DEATH Parkville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2529 Hillcrest Rd.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired-- Insurance		12b. KIND OF BUSINESS OR INDUSTRY						
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Md.	13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INS DE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 2529 Hillcrest Blvd Ave.						
14. FATHER'S NAME William	First Clisham	Middle 	Last 	15. MOTHER'S MAIDEN NAME First Mary	Middle Ellen	Last Ford				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 214-03-47514	17. INFORMANT Mrs. Adelaide Clisham	Address (Same)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		<i>Congestive heart failure</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		<i>Arteriosclerotic cardiovascular disease</i>			10 yrs.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State				
22a. I certify that (I) (this hospital) attended the deceased from January, 1968 , to October 18, 1968 , that (I) (we) last saw the deceased alive on October 17, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>A. Allan Spier</i>	MD	DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 10/18/68					
22d. PHYSICIAN'S NAME (Type) A. Allan Spier	22e. ADDRESS 1501 Penridge Rd.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/21/68.	23c. NAME OF CEMETERY OR CREMATORIAL Lorraine Park Cemetery	23d. LOCATION (City or Town) Baltimore, Md.	(County) 		(State) 				
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214	ADDRESS	25a. REC'D BY REGISTRAR OCT 18 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							



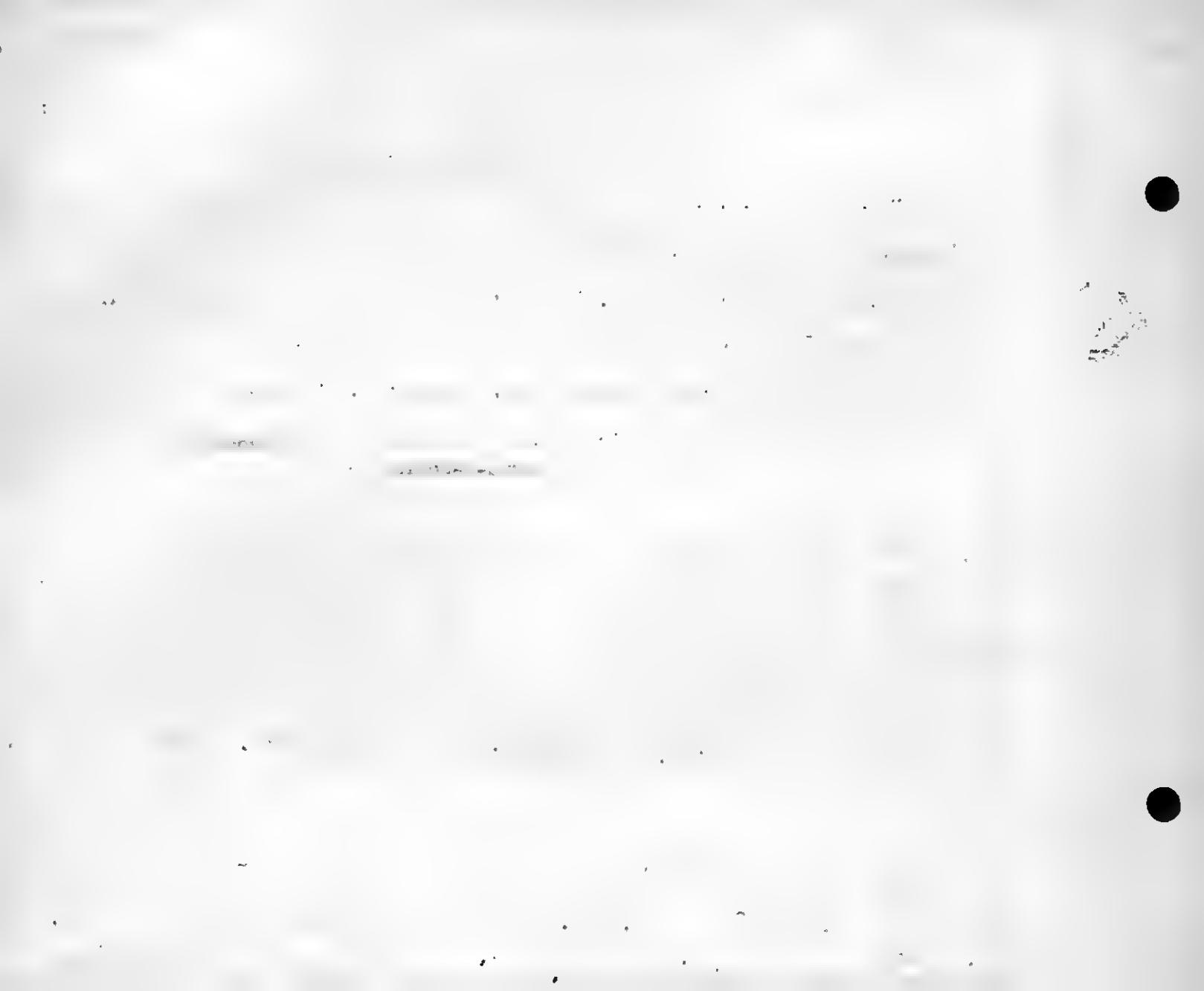
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

13969

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. If you do not have a burial-transit permit, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First HENRY	Middle STIRLING	Lost	2a. DATE OF DEATH Month October	Year 3, 1968	2b. HOUR PM 10:40			
3 SEX MALE	4. RACE WHITE	S. DATE OF BIRTH January 28, 1921	6. AGE (in years lost birthday) 47	7. IF UNDER 1 YEAR MONTHS 0	DAY 0	8. IF UNDER 24 HRS HOURS 0			
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore						
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Manager	12b. KIND OF BUSINESS OR INDUSTRY Service Duplicating						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Baltimore Co.	13c. CITY OR TOWN Balto. 34	13d. INSIDE CITY LIMIT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 2463 Woodcroft Rd. 21234					
14. FATHER'S NAME First Harry	Middle W.	Lost Cochran	15. MOTHER'S MAIDEN NAME First Beatrice	Middle Murphy	Address (Same)				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes	16b. SOCIAL SECURITY NO. (If yes, give war or dates of service) WWII 216-12-5637	17. INFORMANT Mrs. Eleanor K. Cochran	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral hemorrhage secondary to hypertensive cardio-vascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF lost (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Oct. 3, 1968 to Oct. 3, 1968 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on Oct. 3, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE <i>Christina Feliciano, M.D.</i>		DEGREE ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 10/4/68				
22d. PHYSICIAN'S NAME (Type) Christina Feliciano, M.D.		22e. ADDRESS 7620 York Rd., Towson, Md. 21204							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/7/68		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS St. John's		23d. LOCATION (City or Town) Longgreen		(County) Md.	(State)
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Rd. Balto. 12, Md.		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13970

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1-3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME <i>Coffin, Roscoe</i>	First	Middle	Last	2a. DATE OF DEATH Month 10 Day 13 Year 68 1 PM	2b. HOUR 1 PM
3. SEX <i>M</i>	4 RACE <i>W</i>		5. DATE OF BIRTH <i>9/15/72</i>	6. AGE (in years last birthday) <i>96 yrs.</i>	IF UNDER 1 YEAR MONTHS IF UNDER 24 MRS. DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>PENNA.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Baltimore</i>		
10. CITY OR TOWN OF DEATH <i>Catoonsville</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Summit</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Optometrist</i>	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>md</i>	13b. CITY OR TOWN <i>Baltimore</i>	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>1420 Bottom</i>		
14. FATHER'S NAME First <i>George</i>	Middle <i>Street</i>	Last <i>Coffin</i>	15. MOTHER'S MAIDEN NAME First <i>Susan May</i>	Middle	Last <i>Kamus</i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO <i>220-20-154</i>	17. INFORMANT <i>Mrs William</i>	Address <i>Campbell 241 Hunt Lub Rd.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</i>					
DUE TO, OR AS A CONSEQUENCE OF (b) <i>CONGESTIVE HEART FAILURE</i> 12 hrs.					
DUE TO, OR AS A CONSEQUENCE OF (c) <i>PNEUMONIA</i> 12 hrs.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, business, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <i>7/9</i> , 19 <i>68</i> , to <i>10/13</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>10/13</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>S. Lewis the M.D.</i>		DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED <i>10/13/68</i>
22d. PHYSICIAN'S NAME (Type) <i>Harry H. Witzke</i>		22e. ADDRESS			
23a. BURIAL, CREMAT. ON, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>Oct. 16, 1968</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Crestlawn Cemetery</i>	23d. LOCATION (City or Town) <i>Ellicott City, Howard Co., Md.</i>	(County)	(State)
24. FUNERAL DIRECTOR <i>Harry H. Witzke</i>	321 Columbia Pike Ellicott City, Md. 21043	25a. REC'D BY REGISTRAR DA OCT 16 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First JAMES	Middle DEWEY	Lost	2a. DATE OF DEATH Month OCTOBER 4, 1968 Year	2b. HOUR
3. SEX Male	4 RACE White	S. DATE OF BIRTH May 23, 1898	6. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore		
10. CITY OR TOWN OF DEATH Rodgers Forge	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 408 Dunkirk Rd.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Clerk	12b. KIND OF BUSINESS OR INDUSTRY B&O Rail- ROAD		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Rodgers Forge	13d. INSIDE CITY LIMITS? NO	13e. STREET AND NUMBER 408 Dunkirk Rd.	
14. FATHER'S NAME Charles M. Cole	First Middle Lost	15. MOTHER'S MAIDEN NAME Emma W. Weinrich	Middle Lost		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Lillian G. Cole	Address Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> APPROXIMATE INTERVAL DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <u>Congestive heart failure</u> BETWEEN ONSET AND DEATH 12 hours (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of Prostate</u> 1 year. 10 years					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 177x					
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1946</u> to <u>Oct 8, 1968</u> , that (I) (we) last saw the deceased alive on <u>4 Oct 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Charles A. Reier MD</u>	DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED Oct 8, 1968	
22d. PHYSICIAN'S NAME (Type) Dr. Charles A. Reier	22e. ADDRESS 6701 York Rd. Baltimore, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10-7-68	23c. NAME OF CEMETERY OR CREMATORIAL Parkwood	23d. LOCATION (City or Town) Baltimore, Md.	(County)	(State)
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Md.	ADDRESS	25a. REC'D BY REGISTRAR DATE OCT 8 1968	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



FOR STATE
HEALTH DEPT.

Any delay is
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form BMG Page
5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of
Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13862

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13972

1 DECEASED NAME (Type or Print)	First	Middle	Last	2a DATE KNOWN OF ESTI- DEATH MATED	Month	D Year	2b HOUR
Raymond Edward Colliflower, Jr.				10 3		1968 8:30 A.M.	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR	F UNDER 24 HRS.		
Male	White	Sept. 14, 1928	40 yrs	MONTHS	DAYS	HOURS	MIN
7a BIRTHPLACE (State or foreign country) Md.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore			
10 CITY OR TOWN OF DEATH Edmondson Heights		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1502 Clairidge Rd.		12a USUAL OCCUPATION (Kind of work done during most of working life even if retired.) Civil Engineer		12b. KIND OF BUSINESS OR INDUSTRY Baltimore City	
13a USUAL RESIDENCE (Where deceased admiss on) STATE Md.	13b. COUNTY Baltimore	13c CITY OR TOWN Ed. Hights	13d INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER 1502 Clairidge Rd.			
14 FATHER'S NAME Raymond E. Colliflower, Sr.	First	Middle	Last	15. MOTHER'S MAIDEN NAME Mary R. Colley	First	Middle	Last
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b SOCIAL SECURITY NO (If yes give war or dates of service) 217-24-3997	17. INFORMANT Mrs. Mary R. Colliflower	ADDRESS 1502 Clairidge Rd.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last { Due to, or as a consequence of (b) _____ Due to, or as a consequence of (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days - ?					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) Hyper tension, cardiovascular disease 4 yrs							
19a MEDICAL CERTIFICATION DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No.		City or Town	County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)					
23a BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE 10-7-1968		23c NAME OF CEMETERY OR CREMATORIUM Lorraine Park		23d LOCATION (City or Town) Woodlawn (County) Md. (State)	
24 FUNERAL DIRECTOR G. Howard Strong 3207 W. North Ave.,		ADDRESS		25a REC'D BY REGISTRAR DATE OCT 7 1968		25b REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13962

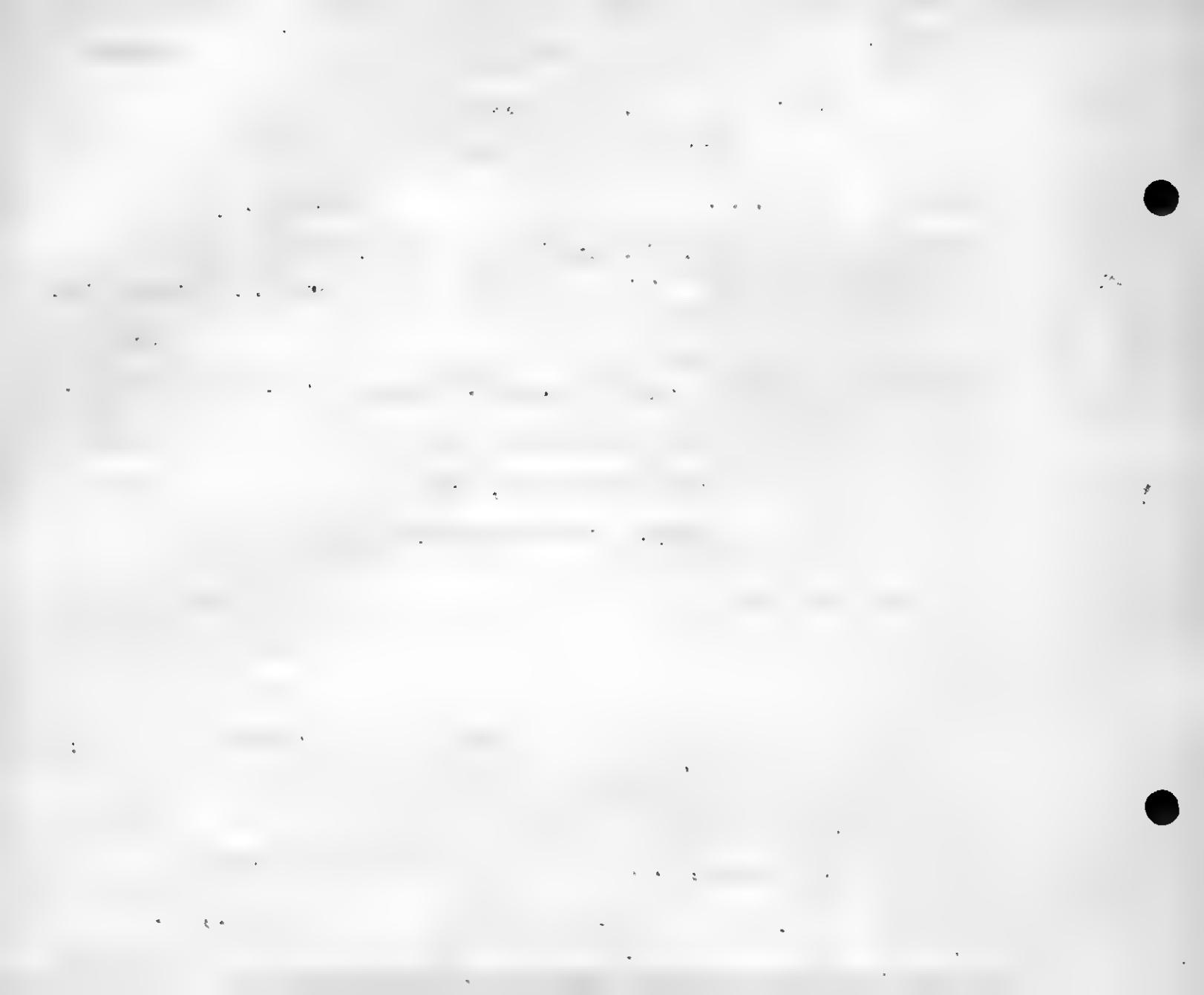
13973

1 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

2 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it may be retained by the hospital or attending physician. If either, notify medical examiner.

3 After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 DECEASED NAME (Type or print)	First JAMES	Middle W.	Last CONWAY	2a. DATE OF DEATH Month 10	Day 15	Year 68	2b. HOUR 6:15PM	
3. SEX MALE	4 RACE NEGRO	5. DATE OF BIRTH 11/25/96			6. AGE (In years last birthday) 71	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	B. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE,		
10. CITY OR TOWN OF DEATH FORT HOWARD	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VET. ADM. HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) PAPER HANGER			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) MARYLAND	13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY, J.M. IS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 932 W. LEXINGTON STREET				
14. FATHER'S NAME First WW II	Middle	Last	15. MOTHER'S MAIDEN NAME First LULA	Middle	Last FLETCHER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	16b. SOCIAL SECURITY NO 217 14 91 42	17 INFORMANT CLIN. RECORDS, VA HOSP. FORT HOWARD, MD.	Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, UNKNOWN ETIOLOGY						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS		
1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last METASTASES TO BRAIN, BONES						UNKNOWN		
DUE TO, OR AS A CONSEQUENCE OF (b) SQUAMOUS CELL CARCINOMA LEFT LUNG								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
MEDICAL CERTIFICATION		19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from 8/28/68 , 19_____, to 10/15/68 , 19_____, that (I/we) last saw the deceased alive on 10/15/68 , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I)(we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Neilson M.D.</i>		DEGREE ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 10/16/68			
22d. PHYSICIAN'S NAME (Type) NEILSON NEILSON, M.D.		22e. ADDRESS VAH FORT HOWARD, MARYLAND						
23a. BURIAL, CREMATION, BURIAL/CREMATION REMOVAL (Specify)		23b. DATE 10-21-68	23c. NAME OF CEMETERY OR CREMATORIAL BALTIMORE NATIONAL	23d. LOCATION (City or Town) BALTIMORE, MD.	(County) (State)			
24. FUNERAL DIRECTOR <i>Charles J. Wilson</i>		ADDRESS WILSON FUNERAL HOME	25a. REC'D BY REGISTRAR OCT 21 1968	25b. REGISTRAR'S SIGNATURE <i>Charles J. Wilson</i>				
VR A 30M REV 68		1000 Brantley Ave.	Baltimore, Md.					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13963

13974

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First <i>Lottie GAY</i>	Middle <i>Cutrens</i>	Last <i>10</i>	2a. DATE OF DEATH Month <i>Oct</i> Day <i>25</i> Year <i>68</i>	2b. HOUR <i>6:30</i>	
3 SEX <i>F</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>3.27.1911</i>		6. AGE (In years last birthday) <i>57 yrs.</i>	F. UNDER 1 YEAR MONTHS <i>5</i> DAYS <i>7</i> HOURS <i>0</i> MIN <i>0</i>		
7a. BIRTHPLACE (State or foreign country) <i>Virginia</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>BALTIMORE</i>			
10. CITY OR TOWN OF DEATH <i>Glen Arm</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Long Green Rd</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>A homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE <i>Md</i>	13b. COUNTY <i>BALTO.</i>	13c. CITY OR TOWN <i>Glen Arm</i>	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER <i>Long Green Rd</i>			
14. FATHER'S NAME First <i>John</i>	Middle <i>Smith</i>	15. MOTHER'S MAIDEN NAME First <i>Priscilla</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <i>218463474</i>	17. INFORMANT <i>Robert Chester Cyrenes, Son</i>	Address <i>1315 1/2 Senechal St., Baltimore, Md.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma of Colon.</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 years.</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>lost.</i>							
DUE TO, OR AS A CONSEQUENCE OF (b) <i></i>							
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION <i>Sep. 29, 1967</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Carcinoma</i>		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i></i>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> contributing <input type="checkbox"/> cause of death (If either, notify medical examiner) <i></i>		21b. TIME OF INJURY HOUR A.M. <i>10</i> Month <i>Oct</i> Day <i>25</i> Year <i>68</i> P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) <i></i>				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <i></i>	21f. LOCATION Street or R.F.D. No <i></i>	City or Town <i></i>		County <i></i>	State <i></i>
22a. I certify that (I) (this hospital) attended the deceased from <i>10.25.1967</i> , to <i>10.25.1968</i> , that (I) (we) last saw the deceased alive on <i>10.19.1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Keith A. Manley</i>		DEGREE <i>MD</i>	ATTENDING PHYS <input checked="" type="checkbox"/>	DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <i>10.26.68</i>	
22d. PHYSICIAN'S NAME (Type) <i>Keith A. Manley</i>		22e. ADDRESS <i>2045, YORK ROAD, TOWSON, MD 21204</i>					
23a. BURIAL, CREMATION OR REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>10/28/68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Church of the Brethren</i>		23d. LOCATION (City or Town) <i>Towson, MD</i>	P (Country) <i></i>	(State) <i></i>	
24. FUNERAL DIRECTOR <i>W. Cook-Burke, Towson, MD 21204</i>		ADDRESS <i>1058 York Rd</i>	25a. REC'D BY REGISTRAR <i>OCT 29 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13975

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of her death.

1. DECEASED NAME (Type or print)		First <i>DAVID</i>	Middle <i>W.</i>	Last <i>DALLAS SR</i>	2a. DATE OF DEATH Month <i>10</i>	Day <i>12</i>	Year <i>1968</i>	2b. HOUR <i>2 PM</i>		
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>May 19 1895</i>		6. AGE (in years last birthday) <i>73</i>		7. J. UNDER 1 YEAR MONTHS <i>0</i>	8. J. UNDER 24 HRS DAYS <i>0</i>	9. J. HOURS MIN <i>0</i>
7a. BIRTHPLACE (State or foreign country) <i>PENN</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED		9. COUNTY OF DEATH <i>(Parkville) Baltimore, Md.</i>				
10. CITY OR TOWN OF DEATH <i>Parkville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>2601 Pitty Hill Ave</i>		12a. USUAL OCCUPATION (Kind of work done during much of working life, even if retired.) <i>Security</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>BANK</i>				
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <i>Md</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Parkville</i>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET AND NUMBER <i>2601 Pitty Hill Ave</i>		
14. FATHER'S NAME First <i>William</i>		Middle <i>W.</i>	Last <i>Dallas</i>	15. MOTHER'S MAIDEN NAME First <i>Mary</i>		Middle <i>Boggs</i>	Last <i>Sanne</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <i>No</i>		16b. SOCIAL SECURITY NO. <i>166-78-6691</i>		17. INFORMANT <i>Frances E Dallas</i>		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Circulatory Collapse & congestive failure</i>		DUE TO, OR AS A CONSEQUENCE OF <i>Gastric Carcinoma & metastasis</i>		DUE TO, OR AS A CONSEQUENCE OF <i>with diarrhea</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hr</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>Malnutrition & Debilitation</i>		(b) <i></i>		(c) <i></i>				<i>1 yr</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i></i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <i>10</i> Month <i>Feb</i> Day <i>18</i> Year <i>1968</i> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) <i></i>						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <i></i>		21f. LOCATION Street or R.F.D. No. <i>10005</i> City or Town <i>Hartford</i> County <i>Roslyn</i> State <i>Penn</i>						
22a. I certify that (I) (this hospital) attended the deceased from <i>Feb 18 1968</i> to <i>Oct 6 1968</i> , that (I) (we) last saw the deceased alive on <i>Feb 18 1968</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.										
22b. SIGNATURE <i>Frank T. Evans Jr.</i>		22c. DEGREE <i>M.D.</i>		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. DATE SIGNED <i>10/19/68</i>				
22d. PHYSICIAN'S NAME (Type) <i>FRANK T. EVANS JR.</i>		22e. ADDRESS <i>9005 Hartford Rd</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>10/19/68</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Hillside Cemetery</i>		23d. LOCATION (City or Town) <i>Roslyn</i> (County) <i>Penn</i> (State) <i>Penn</i>				
24. FUNERAL DIRECTOR <i>Chas. T. Evans Jr.</i>		ADDRESS <i>8802 Hartford Rd</i>		25a. REC'D. BY REGISTRAR DATE <i>OCT 22 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

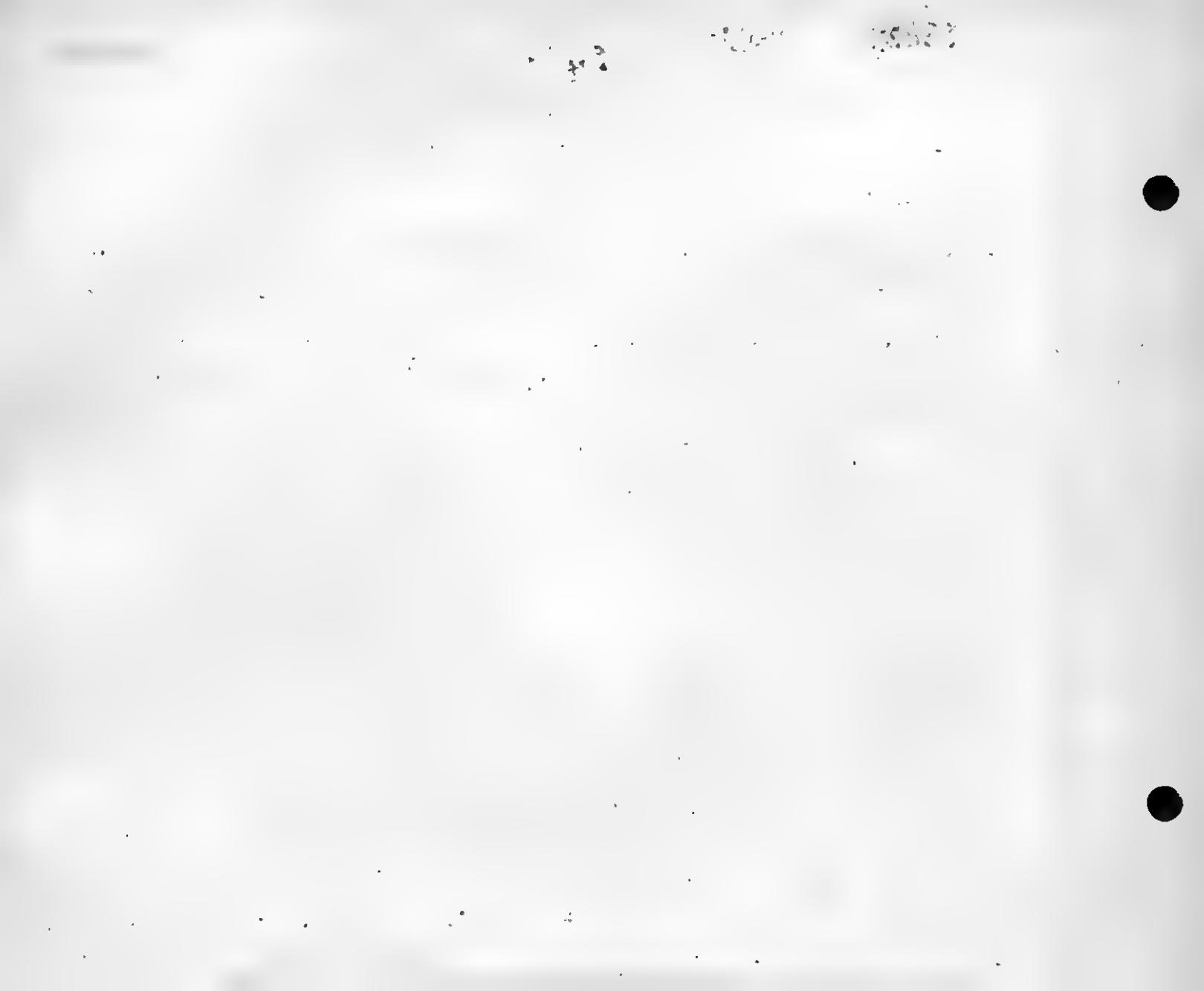
13820

13832

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be surrendered within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First Baby Boy	Middle Karl	Last DANNENFELSER	2a. DATE OF DEATH Month 10	Day 5	Year 68	2b. HOUR M
3. SEX Male	4. RACE Cau	5. DATE OF BIRTH 10/4/68	6. AGE (In years last birthday) YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	HOURS	MIN
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED WIDOWED	9. MARRIED NEVER MARRIED DIVORCED	9. COUNTY OF DEATH Baltimore			
10. CITY OR TOWN OF DEATH Baltimore Towson	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Med. Center			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) None			12b. KIND OF BUSINESS OR INDUSTRY None
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Harford	13c. CITY OR TOWN Forest Hill	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 234 Bynum Ridge Road			
14. FATHER'S NAME Robert	First James	Middle DANNENFELSER	Last Doris	15. MOTHER'S MAIDEN NAME Virginia	Middle Marsh	Last Doris	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) None	17. INFORMANT (Father) E38-0935 Mr. Robert J. DANNENFELSER			Address 234 Bynum Ridge Rd. (Rt. #2) Forest Hill, Maryland 21050		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure 1161 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 7735 (b) Hyaline membrane disease DUE TO, OR AS A CONSEQUENCE OF (c)							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
Prematurity							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
MEDICAL CERTIFICATION 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from 10/4, 1968, to 10/5, 1968, that (I) (we) last saw the deceased alive on 10/5, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Rudiger Breitenecker</i>		DEGREE ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED 10/5/68		
22d. PHYSICIAN'S NAME (Type) Rudiger Breitenecker, M.D.		22e. ADDRESS 6701 N. Charles Street					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Oct. 7, 1968	23c. NAME OF CEMETERY OR CREMATORIUM St. Ignatius Cath. Ch. Cem.	23d. LOCATION (City or Town) Bel Air, Harford Co., Maryland 21014	(County) (State)			
24. FUNERAL DIRECTOR Joseph William Foster	ADDRESS W. Broadway & Williams St. Bel Air, Maryland 21014	25a. REC'D BY REGISTRAR OCT 8 1968	25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13965

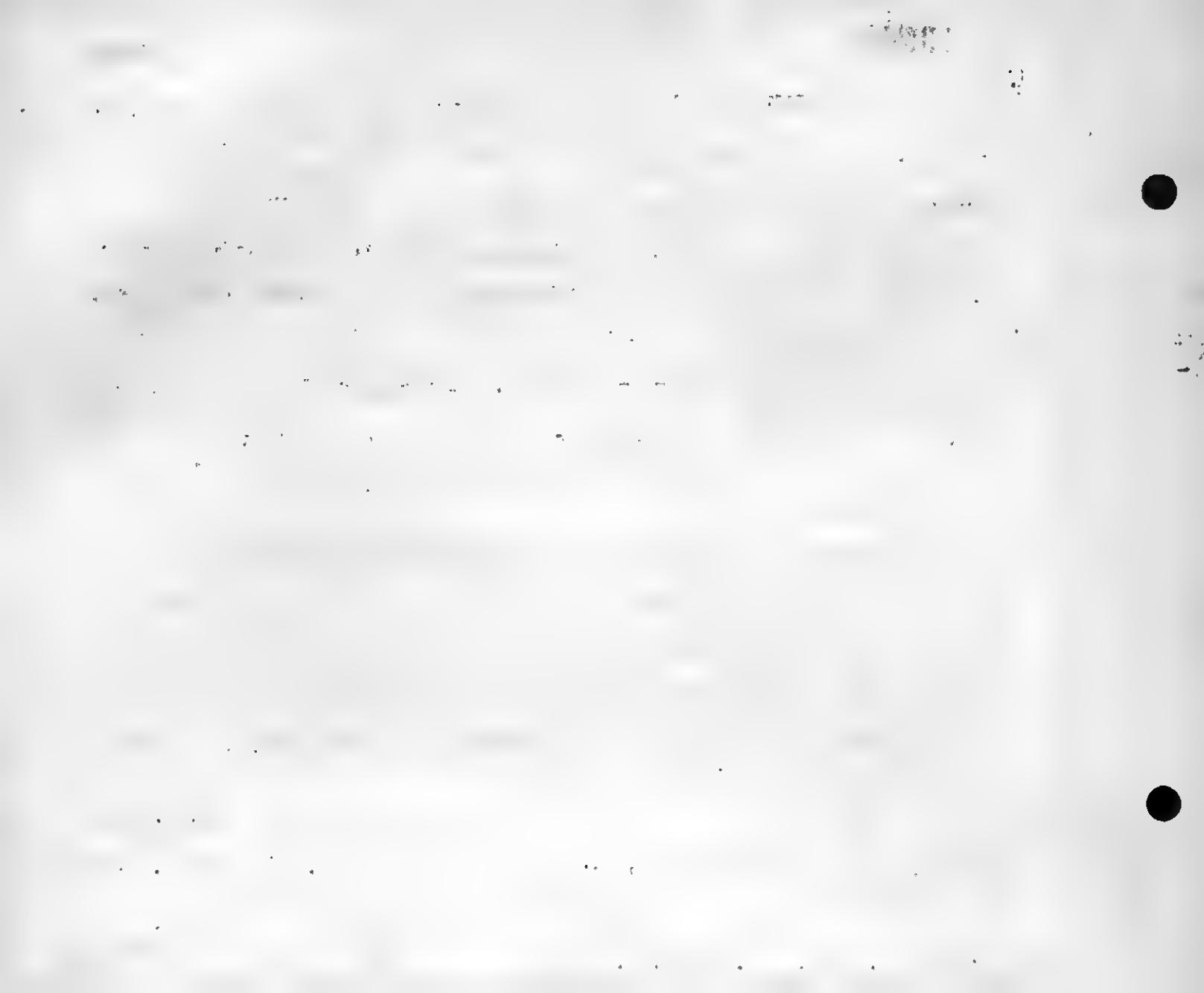
CERTIFICATE OF DEATH

13976

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or print)	First Brian Bryn Protheroe	Middle	Last DAVIES	2a. DATE OF DEATH Month 10	Day 28	Year 1968	2b. HOUR 2 P. M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH June 10, 1902			6. AGE (In years last birthday) 68 yrs.		
7a. BIRTHPLACE (State or foreign country) Whales	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Baltimore,			10. IF UNDER 1 YEAR MONTHS 0	11. IF UNDER 24 HRS. MONTHS 0
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Industrial Engineer		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Res dence before admission) STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 4000 Parkwood Ave.	12b. KIND OF BUSINESS OR INDUSTRY	
14. FATHER'S NAME First Thomas	Middle Davies	15. MOTHER'S MAIDEN NAME First Mary			Middle Protheroe	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No	16b. SOCIAL SECURITY NO 212-09-8062	16c. INFORMANT Mrs. Elizabeth Ann Davies			Address (Same)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchogenic carcinoma of the right lung</i> DUE TO, OR AS A CONSEQUENCE OF <i>XXXXXXXXXXXXXX with extensive metastasis to</i> (b) <i>liver and left adrenal gland.</i> DUE TO, OR AS A CONSEQUENCE OF (c)							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10/18/1968 to 10/28/1968 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10/28/1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Christina Feliciano, M.D.</i>		22c. DATE SIGNED 10/28/68					
22d. PHYSICIAN'S NAME (Type) Christina Feliciano, M.D.		22e. ADDRESS 7620 York Rd., Towson, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11/1/68.	23c. NAME OF CEMETERY OR CREMATORIUM Slateville Cemetery			23d. LOCATION (City or Town) Delta, Pa.	(County) 0	(State) 0
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214	ADDRESS Leonard J. Ruck, Inc. Balto. Md. 21214			25a. REG'D BY REGISTRAR OCT 30 1968	25b. REGISTRAR'S SIGNATURE <i>Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13977

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First JOHN	Middle LARKIN	Last DAWSON	2a. DATE OF DEATH 10 Month 8 Day 68 Year	2b. HOUR A.M. 7:57 M
3. SEX MALE	4. RACE White	5. DATE OF BIRTH 11-26-1912		6. AGE (in years last birthday) 55 yrs.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Baltimore	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GR. BALTO. MED. CENTER		12a. US/JAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE X X X X X Pa.		12b. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Agent - Trucking Co.
13a. US/JAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE X X X X X Pa.	13c. CITY OR TOWN Loysburg, Pa.	13d. INS. OF CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Loysburg, Pennsylvania		
14. FATHER'S NAME James	First Dawson	Middle 	Last 	15. MOTHER'S MAIDEN NAME Loretta	Middle
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT Virginia Dawson - Loysburg, Pennsylvania Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF COMPLETE ESOHPAGEAL OBSTRUCTION (c) DUE TO, OR AS A CONSEQUENCE OF CA ESOPHAGUS					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION 9/25		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. CURRENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from 9-18 , 19 68 , to 10-8 , 19 68 , that (I) (we) last saw the deceased alive on 10/8 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Dost Mohammed		DEGREE ATTENDING PHYS	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS. X	22c. DATE SIGNED 10-8-68
22d. PHYSICIAN'S NAME (Type) DOST MOHAMMED M.D.		22e. ADDRESS 6701 N. CHARLES ST. BALT. MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-11-68	23c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Elsworth Armacost - 4600 Liberty Hghts. Ave.		ADDRESS	25a. REC'D BY REGISTRAR OCT 11 1968	25b. REGISTRAR'S SIGNATURE Charles Judge	

卷之三

4

16

Fig. 1. - A. S. 1000.

17

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

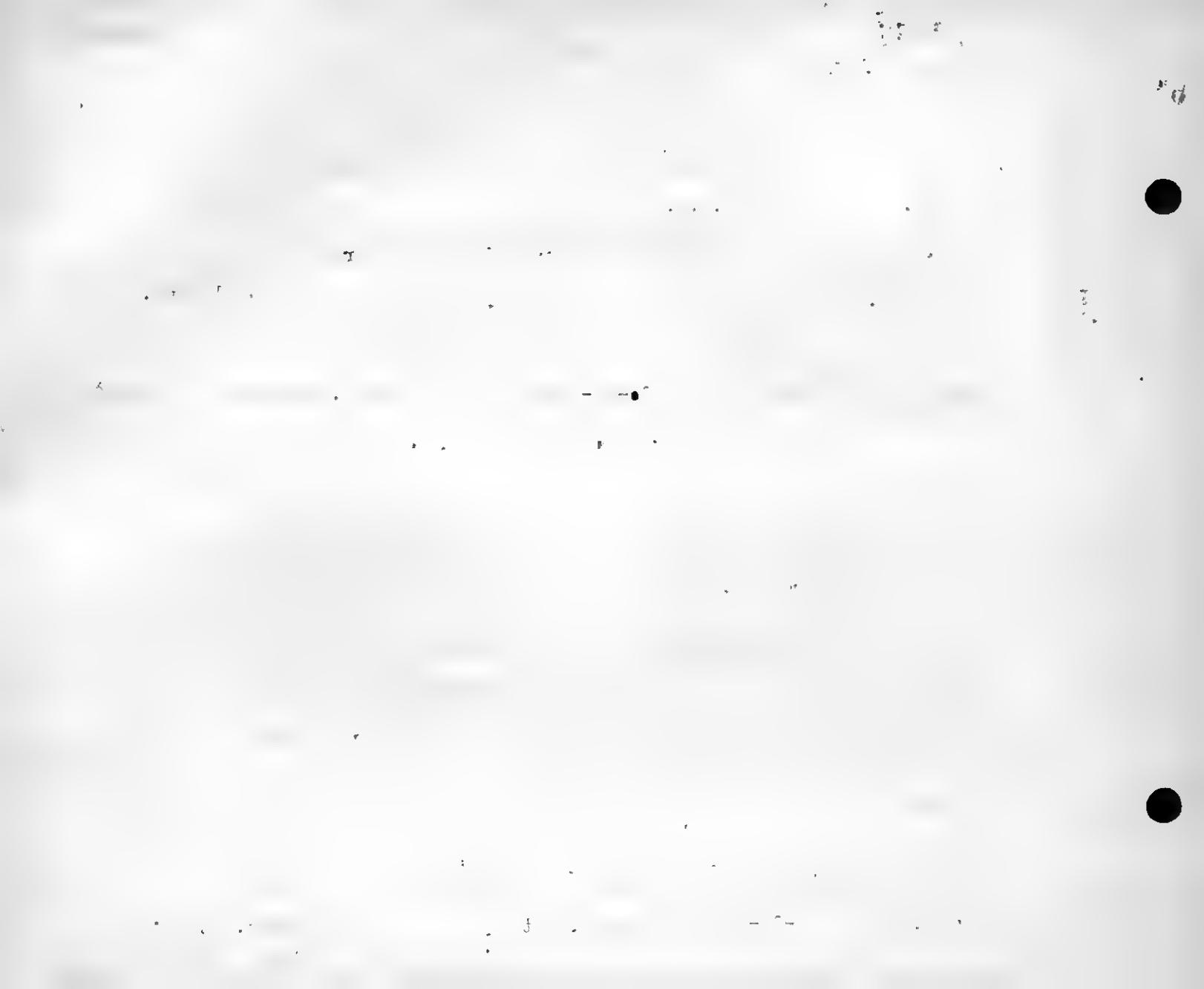
CERTIFICATE OF DEATH

13978

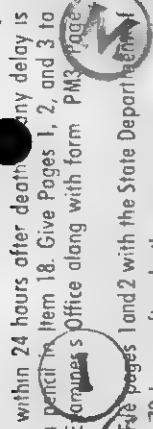
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers P. 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First William	Middle J.	Last Denley	2a. DATE OF DEATH Month 10	Day 28	Year 68	2b. HOUR 9:46A.M.	
3. SEX Male	4 RACE Caucasian	5. DATE OF BIRTH 10/3/27			6 AGE (In years last birthday) 41 yrs		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	9. COUNTY OF DEATH Baltimore					
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balt. Med. Center	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Printer			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.	13b. COUNTY —	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 3329 Elm Ave.				
14. FATHER'S NAME First ?	Middle ?	Last ?	15. MOTHER'S MAIDEN NAME First Eva M. Denley	Middle ?	Last ?	Address (name)		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown yes	16b. SOCIAL SECURITY NO. WV2	17. INFORMANT 22-20-5986			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar pneumonia, bilateral</u>								
481X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 481X <u>Fatty metamorphosis of liver</u>								
19a. MEDICAL CERTIFICATION DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State			
22a. I certify that (I) (this hospital) attended the deceased from 10/24, 19 68, to 10/28, 19 68, that (I) (we) lost saw the deceased alive on 10/28 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						22c. DATE SIGNED 10/28/68		
22b. SIGNATURE <u>Rudiger Breitenecker</u>	DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/>	MED. DIRECTOR	<input type="checkbox"/>	STAFF PHYS	<input type="checkbox"/>		
22d. PHYSICIAN'S NAME (Type) Rudiger Breitenecker, M.D.	22e. ADDRESS 6701 N. Charles Street							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10-31-68	23c. NAME OF CEMETERY OR CREMATORIAL Balto. Nat	23d. LOCATION (City or Town) Balto. Co.		(County) Md.		(State)	
24. FUNERAL DIRECTOR <u>Paul L. Chernowich</u>	ADDRESS 3617 Chester Av.	25a. REC'D BY REGISTRAR NOV 1 1968	25b. REGISTRAR'S SIGNATURE Charles Judge					



FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3-1000C. Pages 1 and 2 with the State Department of Health.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13968

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13979

1. DECEASED NAME (Type or Print)				First	Middle	Last	2a. DATE KNOWN OF ESTI DEATH MATED				Month	Day	Year	2b. HOUR 10-23 19 68 M	
CHARLES DOMONIC DISTEFANO							<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10	23	19	68		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	7. IF UNDER 1 YEAR MONTHS	8. IF UNDER 24 HRS DAYS	9. IF UNDER 24 HRS HOURS	10. DATE PRONOUNCED DEAD Month	11. DATE PRONOUNCED DEAD Day	12. DATE PRONOUNCED DEAD Year	2c. DATE PRONOUNCED DEAD Month	13. DATE PRONOUNCED DEAD Day	14. DATE PRONOUNCED DEAD Year	2d. HOUR 10-30 P.M.		
Male	White	July 29, 1947	21 YRS				October	23,	19 68						
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH		BALTIMORE							
Maryland		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY			
Towson				B.B.M.C. Hospital				Farrier				Horses			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13c. CITY OR TOWN		13d. INSIDE CITY, IN TSP		13e. STREET AND NUMBER							
Md.				Baltimore		Owings Mills		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				Rt. 1 Box 290			
14. FATHER'S NAME				First	Middle	Last	15. MOTHER'S MAIDEN NAME				First	Middle	Last		
Anthony Dominic DiStefano							Carmella L. Manno								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
NO				213-52-6508				Anthony DiStefano				Rt. 1 Box 290 Owings Mills Md.			
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebro-cranial injuries</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>8244</u>															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY?							
								<input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR AM 10:00 10-23 19 68				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Drag racing - fell out of auto							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) street				21f. LOCATION Street or R.F.D. No Tufton Ave. & Falls Rd.				City or Town	County	State	
												Baltimore	Md.		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															22b. DATE SIGNED
Charles S. Springate, M.D.															October 24, 1968
23a. BURIAL, CREMATION, REMOVAL, (Specify) Burial				23b. DATE Oct. 26, 1968				23c. NAME OF CEMETERY OR CREMATORIAL Evergreen Mem. Gardens				23d. LOCATION (City or Town) Finksburg Carroll Md.			
24. FUNERAL DIRECTOR <u>Sgt. Ellhardt</u>				ADDRESS Owings Mills, Md.				25a. RECD. BY REGISTRAR DATE OCT 28 1968				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13980

13964

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First MINNA		Middle ANNA	Lost	2d. DATE OF DEATH Month 10 Day 11 Year 68	2d. DATE OF DEATH Month 10 Day 11 Year 68	2d. DATE OF DEATH Month 10 Day 11 Year 68	2d. DATE OF DEATH Month 10 Day 11 Year 68
3. SEX FEMALE		4 RACE CAUC		S. DATE OF BIRTH 01-18-91	6. AGE (In years lost birthday) 27 yrs.	IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GRTR. BALTO. MED. CENTR.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) None	12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Timonium	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 101 Springside Dr.				
14. FATHER'S NAME First Ludwig Faber		Middle	Lost	15. MOTHER'S MAIDEN NAME First Louisa Raffel		Middle	Lost		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, unknown		16b. SOCIAL SECURITY NO. 212-32-4148 A		17. INFORMANT Miss Betty Lou Faber	Address Same				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		CEREBRO VASCULAR ACCIDENT				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause 2509		DUE TO, OR AS A CONSEQUENCE OF ARTERIOSCLEROTIC HEART DISEASE							
		DUE TO, OR AS A CONSEQUENCE OF DIABETES MELLITUS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)									
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from 10-08 , 19 68 , to 10-11 , 19 68 , that (I) (we) last saw the deceased alive on 10-11 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE D.G. Caralis		DEGREE ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 10-11-68				
22d. PHYSICIAN'S NAME (Type) D.G. CARALIS		22e. ADDRESS GBMC							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10-14-68	23c. NAME OF CEMETERY OR CREMATORIUM Oaklawn			23d. LOCATION (City or Town) Baltimore, Maryland	(County) Baltimore (State) Maryland			
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc.	ADDRESS 6500 York Rd. Baltimore, Md.	25a. REC'D. BY REGISTRAR OCT 17 1968			25b. REGISTRAR'S SIGNATURE Charles Judge				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13970

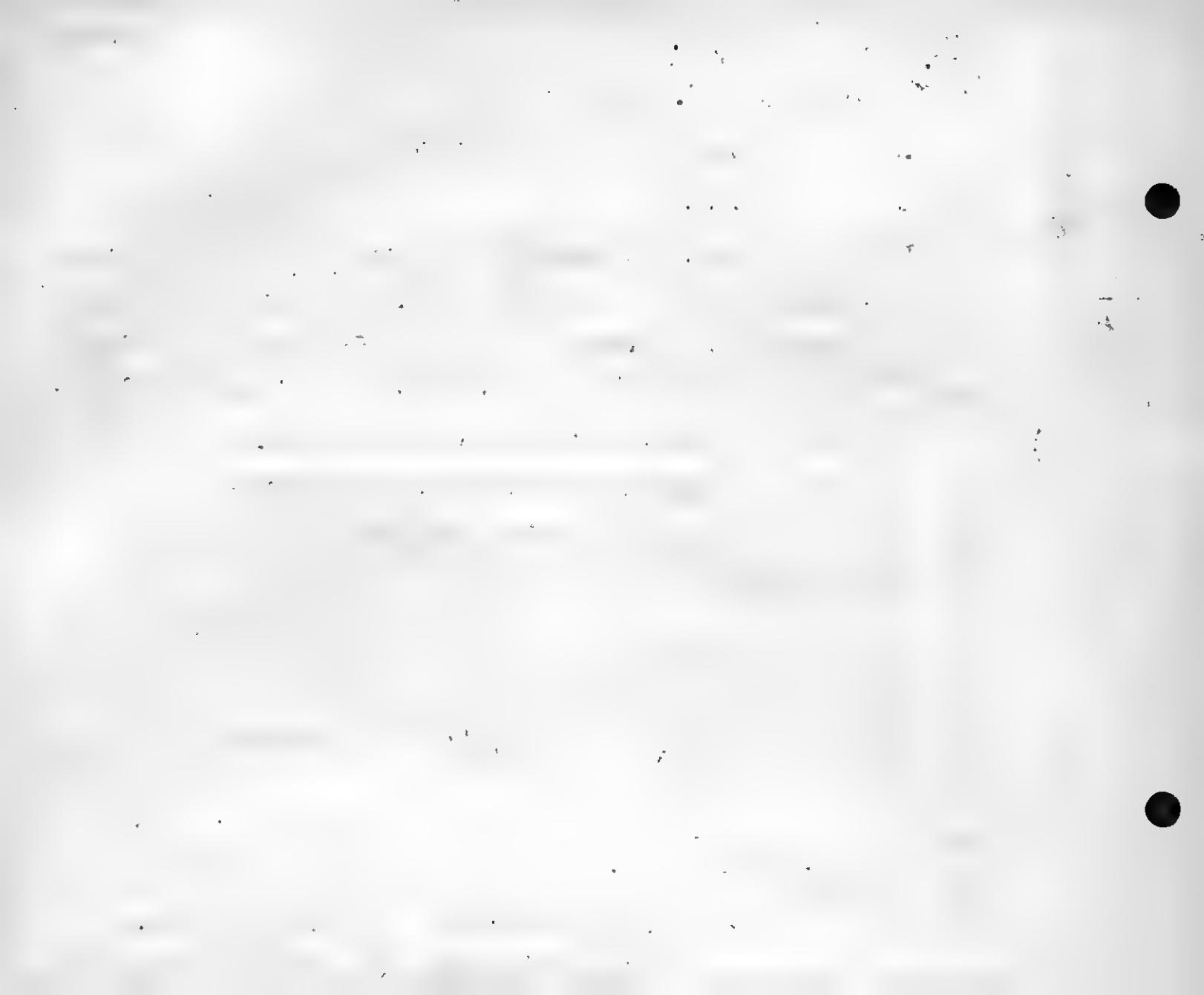
13981

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or the hospital director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 2 hours after death.

1. DECEASED-NAME (Type or print)	First ROBERT	Middle LEE	Last DONNELLY	2a. DATE OF DEATH Month 10 Day 8 Year 68	2b. HOUR 10:35PM
3. SEX MALE	4 RACE WHITE	5. DATE OF BIRTH 4/31/98		6. AGE (In years last birthday) 70 YRS	If UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE COUNTY,		
10 CITY OR TOWN OF DEATH FORT HOWARD	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VET. ADM. HOSPITAL	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) WATCHMAN		12b KIND OF BUSINESS OR INDUSTRY FORD COMPANY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND	13b CITY OR TOWN BALTIMORE	13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 131 E. Gittings Street		
14 FATHER'S NAME First EDWARD	Middle A	Last DONNELLY	15. MOTHER'S MAIDEN NAME RUTH	Middle Rusha	Last MORGAN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES	16b. SOCIAL SECURITY NO. WW I 218 09 48 45	17 INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA, BILATERAL UNDETERMINED ORGANISM			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS		
1621 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
(b) METASTASES TO LYMPH NODES, SPINE & CEREBRUM					
(c) ANAPLASTIC CARCINOMA LEFT LUNG					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) DIABETES MELLITUS					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH NO AUTOPSY	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8/12/68, 19_____, to 10/8/68, 19_____, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10/8/68, 19_____, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (did) <input checked="" type="checkbox"/> view the body after death.					
22b. SIGNATURE <i>neilson neilson MD</i>	DEGREE	ATTENDING PHYS. <input type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED 10/9/68
22d. PHYSICIAN'S NAME (Type) NEILSON NEILSON, M. D.	22e. ADDRESS VAH FORT HOWARD, MARYLAND				
23a. BURIAL, CREMATON, REMOVAL (Specify) BURIAL	23b. DATE 10-11-68	23c. NAME OF CEMETERY OR CREMATORIUM BALTIMORE NATIONAL	23d. LOCATION (City or Town) BALTIMORE, MARYLAND	(County)	(State)
24. FUNERAL DIRECTOR MC GULLY FUNERAL HOME E. FORT AVE. BALTIMORE, MD.	ADDRESS		25a. REGD. BY REGISTRAR OCT 11 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13971.

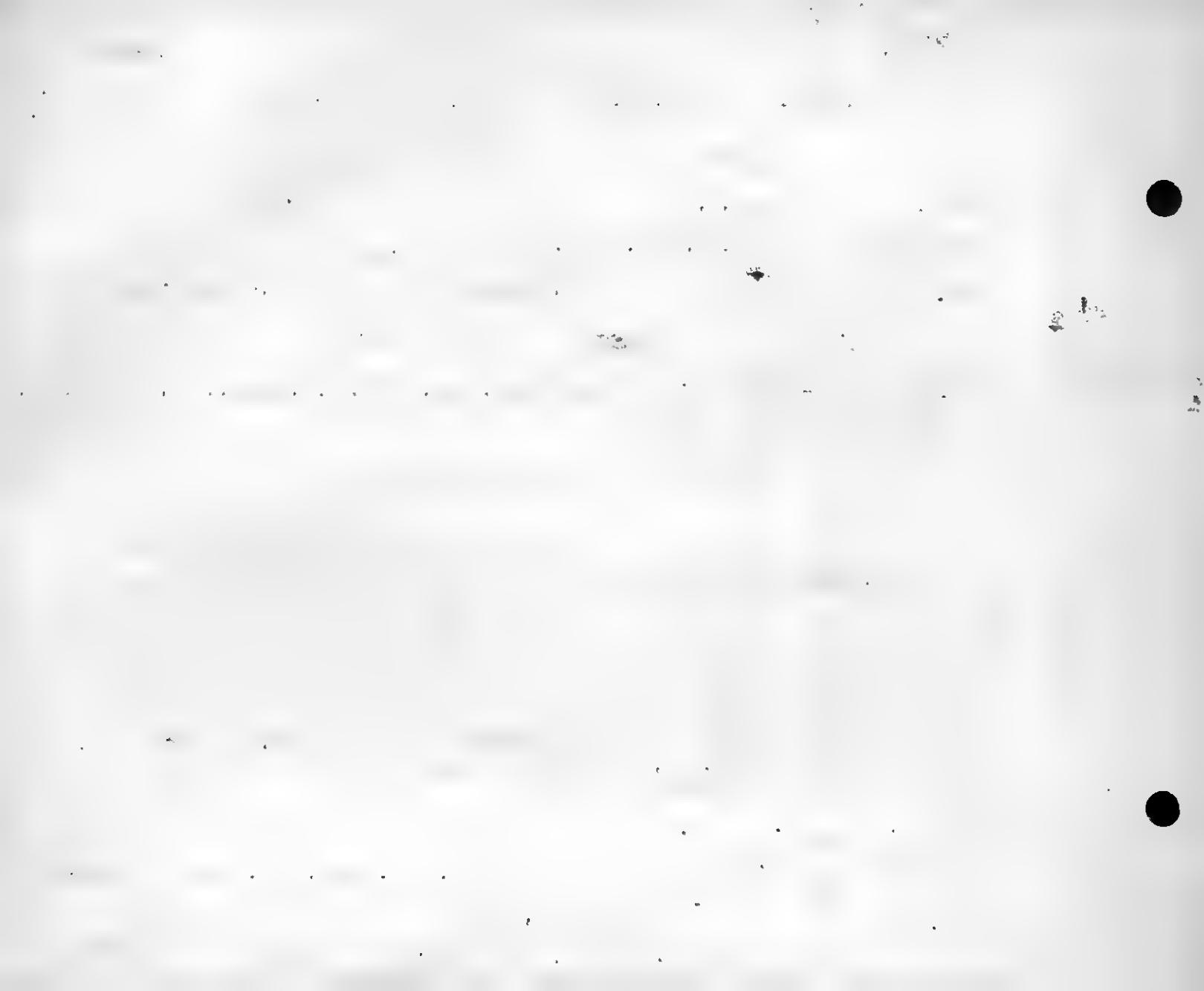
CERTIFICATE OF DEATH

13982

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First JOSEPH	Middle ALEXANDER	Last DORSEY	2a DATE OF DEATH Month OCTOBER	Day 19	Year 1968	2b. HOUR 12:25 P.M.		
3 SEX MALE	4 RACE NEGRO	S. DATE OF BIRTH 5 20 07	6. AGE (In years last birthday) 61 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN					
7a BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE						
10 CITY OR TOWN OF DEATH FORT HOWARD	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give name of odd place) VET. ADM. HOSP.	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) LABORER				12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before adm.) MARYLAND	13b COUNTY BALTIMORE	13c CITY OR TOWN BALTIMORE	13d INSIDE CITY LIMITS <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER 414 ORCHARD STREET					
14 FATHER'S NAME First BILL	Middle DORSEY	15. MOTHER'S MAIDEN NAME First JULIA							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES	16b. SOCIAL SECURITY NO WW-11 217 01 5599	17 INFORMANT CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.	Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) UREMIA 582 X						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. CHRONIC GLOMERULONEPHRITIS (b) DUE TO, OR AS A CONSEQUENCE OF ARTERIOSCLEROTIC HEART DISEASE (c) DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State				
22a. I certify that (1) (this hospital) attended the deceased from March 21, 1968 , to Oct. 19, 1968 , that (4) (we) last saw the deceased alive on Oct. 19, 1968 and that in (4) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (32367) view the body after death.									
22b. SIGNATURE <i>John Talbert M.D.</i>	DEGREE ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 10/21/68					
22d. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.	22e. ADDRESS VET. ADM. HOSP., FT. HOWARD, MARYLAND								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DAY 10/25/68	23c. NAME OF CEMETERY OR CREMATORIAL BALTIMORE NATIONAL	23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND						
24. FUNERAL DIRECTOR Grace W Halstead HALSTEAD FUNERAL HOME	ADDRESS 1206 W North Ave. N. NORTH AVE. BALTIMORE, MD.	25a. REC'D BY REGISTRAR Oct. 22, 1968	25b. REGISTRAR'S SIGNATURE <i>Charles George</i>						



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13983

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached, for use as the burial-transit permit. Then please remove carbon papers. Please send the original to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

1. DECEASED NAME (Type or print)	First . NELLIE	Middle NMN	Last DOUGLASS	2a. DATE OF DEATH Month OCT. 4, 1908 Day 4 Year 1908	2b. HOUR 11:00 A.M.
3. SEX F	4 RACE NEGRO	S. DATE OF BIRTH 7-1-1908	6 AGE (in years last birthday) 60	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore County,		
10 CITY OR TOWN OF DEATH Mount Wilson	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mt. Wilson State Hosp.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD	13c CITY OR TOWN BALTIMORE	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 1314 LAFAYETTE AVE.		
14. FATHER'S NAME First GEORGE Middle NMN Last JOHNSON	15. MOTHER'S MAIDEN NAME First MOLLIE Middle ? UNKN	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? NO	16b. SOCIAL SECURITY NO. 219-22-5194	17. INFORMANT Records, Mt. Wilson State Hospital	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Military tuberculosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 217a (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mos.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Acute uremia					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medico! examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE William Newcomer	DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D.	22e. ADDRESS Mount Wilson, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10-9-1968	23c. NAME OF CEMETERY OR CREMATORIAL Chews Chapel	23d. LOCATION (City or Town) Annapolis	(County) Anne Arundel	(State) Md
24. FUNERAL DIRECTOR Hicks Funeral Home	ADDRESS Annapolis, Md	25a. REC'D BY REGISTRAR DATE OCT 14 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

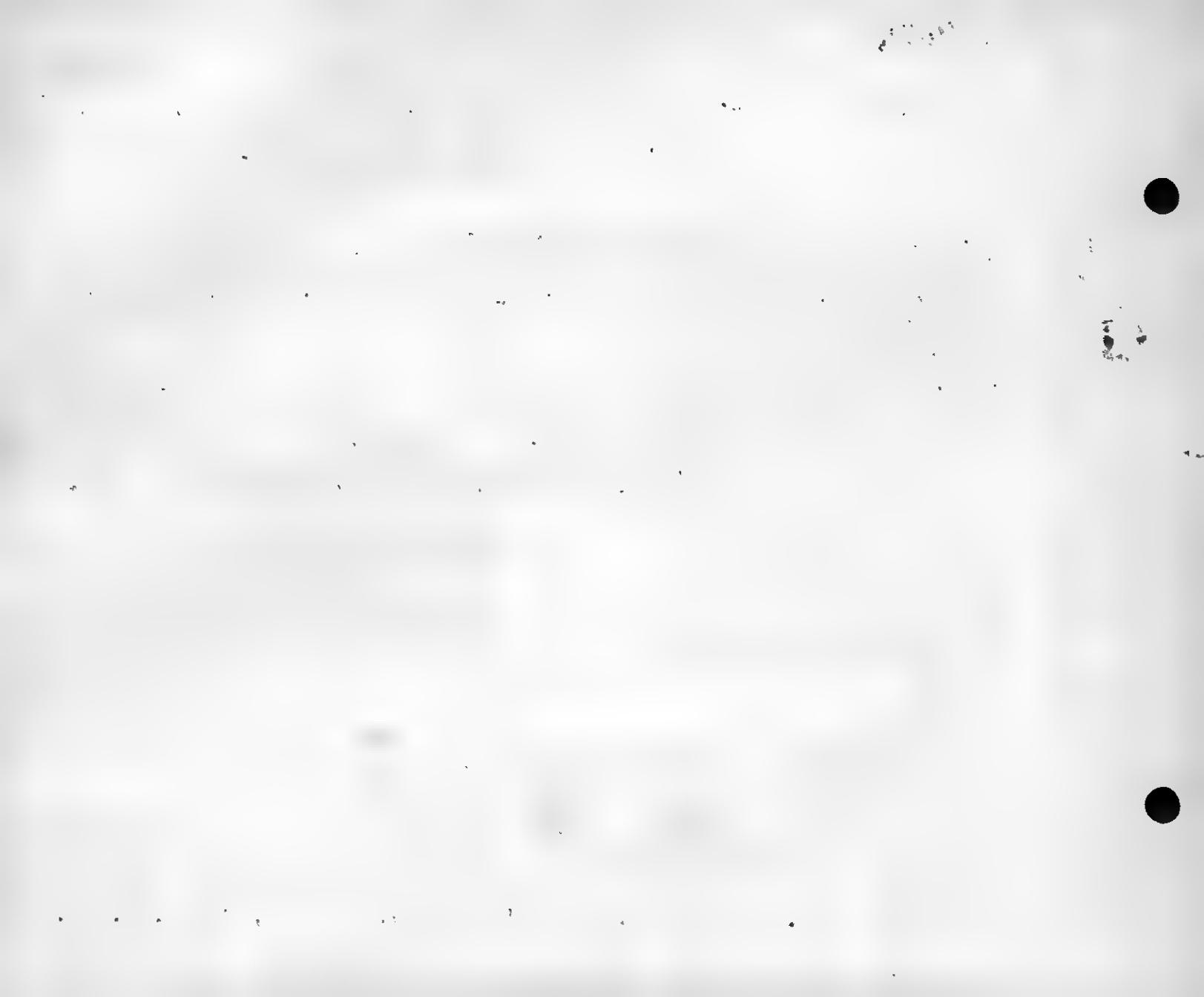
13973

13984

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-tranit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First <i>RICHARD</i>	Middle <i>J.</i>	Last <i>Douglass</i>	2a. DATE OF DEATH Month <i>Oct.</i>	2b. HOUR Year <i>1968 10:35 A.M.</i>	
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>3-13-98</i>		6. AGE (in years last birthday) <i>70 yrs.</i>	F UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS. HOURS <i>0</i>
7a. BIRTHPLACE (State or foreign country) <i>J.C.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Baltimore</i>	Md		
10. CITY OR TOWN OF DEATH <i>BALTIMORE</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Hospital of the Good Samaritan</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Cooking Services Balto Co.</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased admission) STATE <i>Maryland</i>	lived, if institution Resdence before <i>BALTO.</i>	13c. CITY OR TOWN <i>Cockeysville</i>	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER <i>34 Parks Ave.</i>		
14. FATHER'S NAME <i>Unknown</i>	First <i>Unknown</i>	Middle <i>Unknown</i>	Last <i>Unknown</i>	15. MOTHER'S MAIDEN NAME <i>Unknown</i>	Middle <i>Unknown</i>	Last <i>Unknown</i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16b. SOCIAL SECURITY NO (If yes give war or dates of service) <i>212-46-5692</i>	17. INFORMANT <i>wife</i>	Address <i>Some</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						
PART I. DEATH WAS CAUSED BY						
IMMEDIATE CAUSE (a) <i>Myocardial failure</i>						
DUE TO, OR AS A CONSEQUENCE OF						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Atherosclerotic heart disease</i>						
DUE TO, OR AS A CONSEQUENCE OF						
(c)						
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Days</i>						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
Years						
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (i) (this hospital) attended the deceased from saw the deceased alive on <i>OCT 18 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (i) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>RK Gundry MD</i>						
22d. PHYSICIAN'S NAME (Type) <i>R K GUNDY</i>		22e. ADDRESS <i>2 W University Pkwy, #31218</i>		22c. DATE SIGNED <i>10-19-68</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Oct. 21, 1968</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>St. Joseph's Cemetery</i>	23d. LOCATION (City or Town) <i>Texas, Balto. Co., Md.</i>	(County) <i></i>	(State) <i></i>
24. FUNERAL DIRECTOR <i>John Burns' Sons, Towson, Maryland</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE	
				DATE <i>OCT 21 1968</i>		



MARYLAND STATE DEPARTMENT OF HEALTH

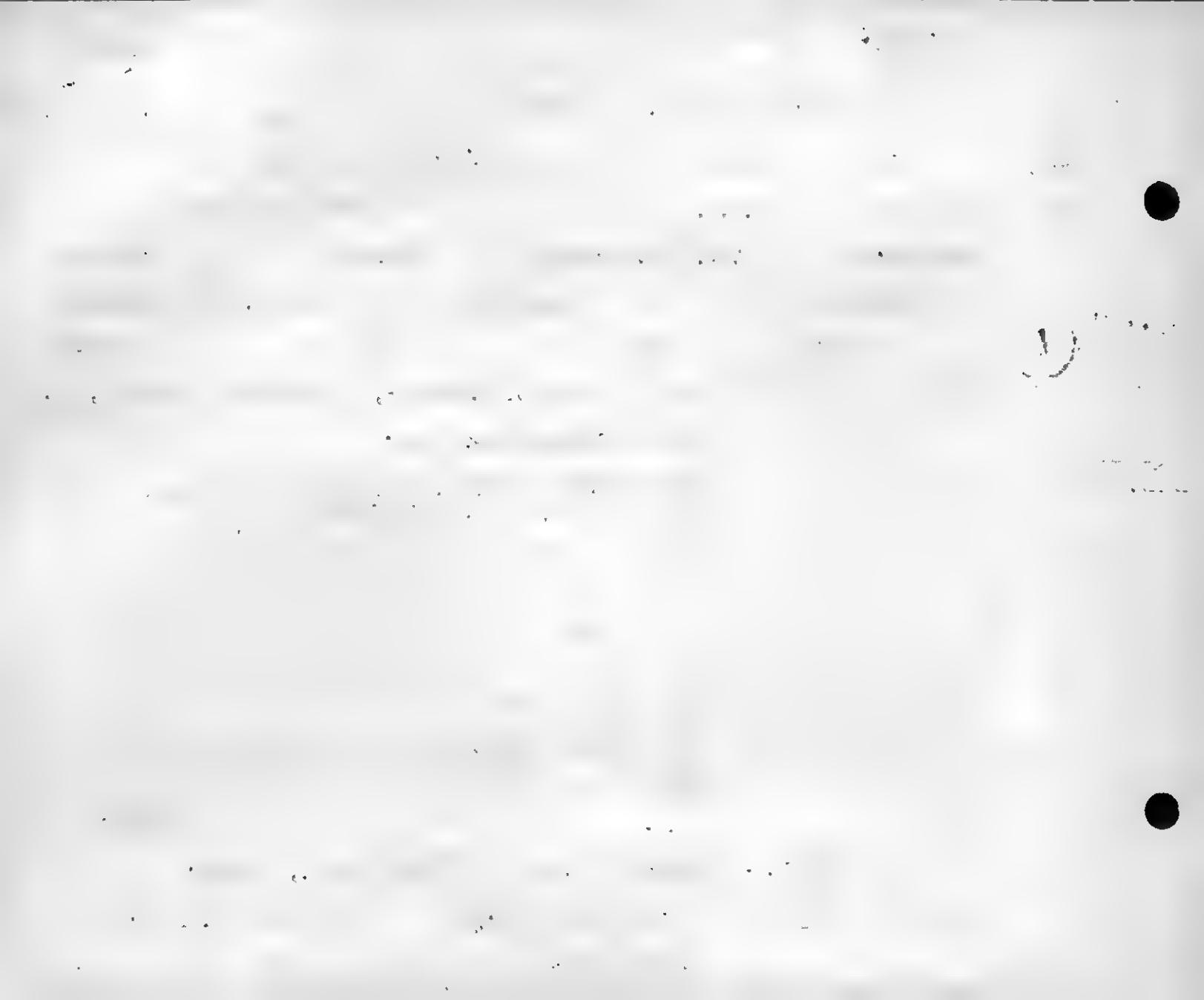
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13985

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and file with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First RAYMOND	Middle R.	Last DOWELL	2a. DATE OF DEATH Month 10	Day 14	Year 68	#b HOUR 11:30P
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 1/10/95			6. AGE (In years last birthday) 73	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0
7a BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED WIDOWED	NEVER MARRIED DIVORCED	9 COUNTY OF DEATH Baltimore County			Md
10 CITY OR TOWN OF DEATH FORT HOWARD	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VET. ADM. HOSPITAL			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) PLUMBER		12b KIND OF BUSINESS OR IND. STBY SHIPYARD	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1623 E. Oliver Street			
14 FATHER'S NAME BENJAMIN	First MIDDLE DOWELL	15 MOTHER'S MAIDEN NAME FANNY			Middle Last ARMSTRONG		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, unknown YES	16b. SOCIAL SECURITY NO WW 1	16c. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.	Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1579 Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF ADENOCARCINOMA PANCREAS WITH METASTASIS TO LIVER, OMENTUM AND PERITONEUM (c) DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION 1579		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State
22a. I certify that (b) (this hospital) attended the deceased from 8/17/68, 19, to 10/14/68, 19, that (b) (we) last saw the deceased alive on 10/14/68 19, and that in (a) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (not) view the body after death.							
22b. SIGNATURE <i>George C. Elfatrick, M.D.</i>		DEGREE ATTENDING PHYS	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS	<input checked="" type="checkbox"/>	22c. DATE SIGNED 10/15/68	
22d. PHYSICIAN'S NAME (Type) GEORGE C. C. ELFATRICK, M. D.		22e. ADDRESS VAH FORT HOWARD, MARYLAND					
23a. BURIAL, CREMATION, Cremation (Specify) BURIAL		23b. DATE 10-18-68	23c. NAME OF CEMETERY OR CREMATORIAL BALTIMORE NATIONAL			23d. LOCATION (City or Town) BALTIMORE, MARYLAND (County) (State)	
24. FUNERAL DIRECTOR		ADDRESS JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD.			25a. REG'D. BY REGISTRAR DATE OCT 18 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

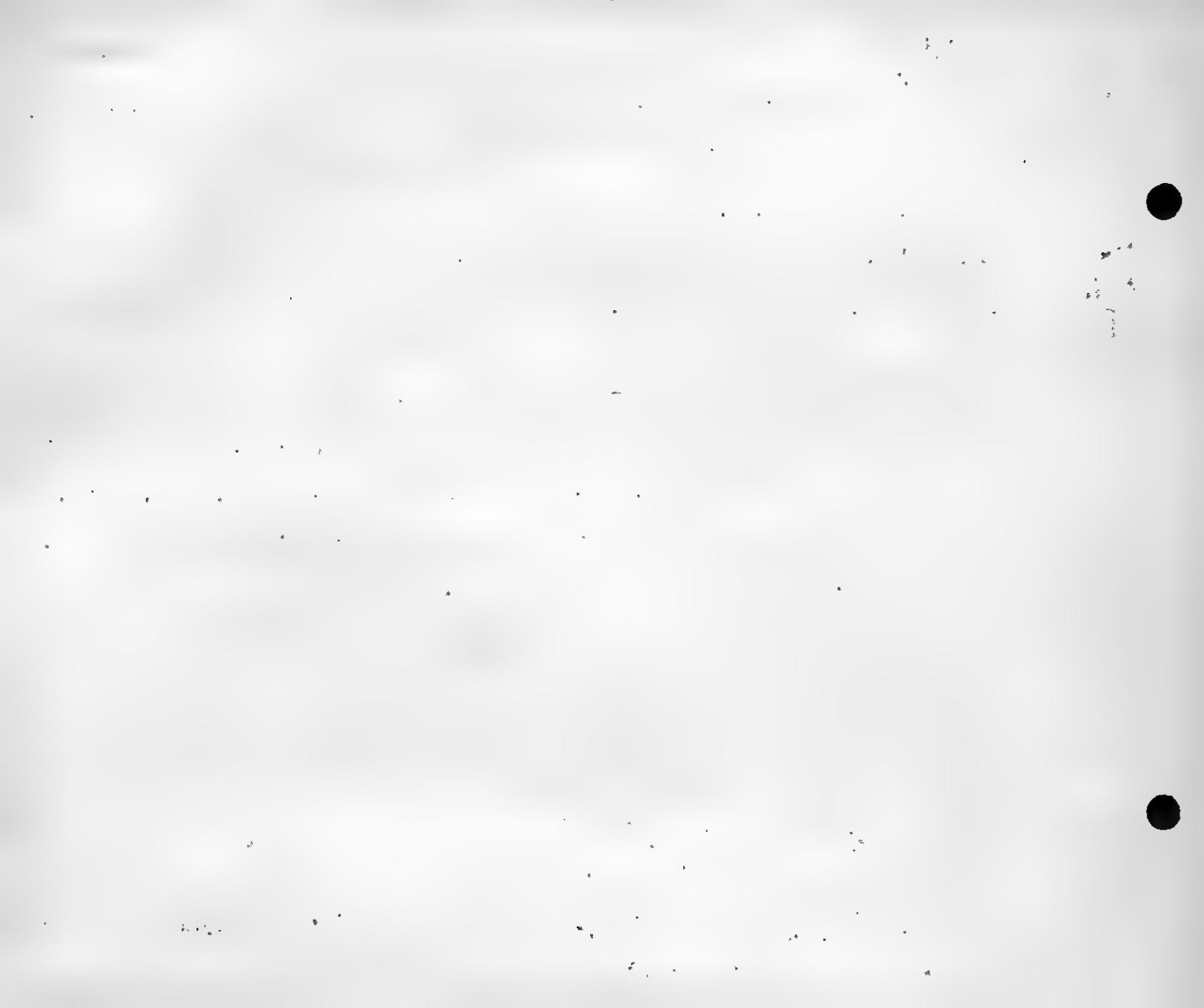
CERTIFICATE OF DEATH

13986

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Charles	Middle J.	Last Drewer	20. DATE OF DEATH Month October Day 11, 1968 Year 1968 Hour 7:45 P.M.	21. HOUR 7:45 P.M.
3. SEX male	4 RACE white	5. DATE OF BIRTH May 17, 1902		6. AGE (In years lost birthday) 66 YRS	F. UNDER MONTHS DAYS HOURS M.N.
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? U. S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Baltimore		
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Cook	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13c. CITY OR TOWN Catonsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 315 Ingleside Avenue	
14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME Griffen	Middle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Navy	16b. SOCIAL SECURITY NO WW II	17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Myocardial Infarction, Acute, Death, Immediate DUE TO, OR AS A CONSEQUENCE OF with chronic atrial fibrillation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Arteriosclerotic, Cardiovascular Ht. Dis. 1 yr. DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis, Generalized, Senile 1 yrs.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Thrombophlebitis, chronic, left leg.					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (s) (this hospital) attended the deceased from March 6 19 68, to Oct. 11, 19 68, that (s) (we) last saw the deceased alive on Oct. 11 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.					
22b. SIGNATURE <i>Anthony J. Young, M.D.</i>	DEGREE ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 10-14-68	
22d. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.	22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228				
23d. BURIAL, CREMATION, REMOVAL (Specify) Burial Oct 16 1968	23b. DATE 23c. NAME OF CEMETERY OR CREMATORIAL Bryn Haven Cemetery	23d. LOCATION (City or Town) Ritchie Holiday Inn	(County) Baltimore	(State) Md	
24. FUNERAL DIRECTOR Krause Funeral Home	ADDRESS 12165 Charles St	250. REC'D BY REGISTRAR OCT 21 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13987

13976

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First CHARLES	Middle A.	Last DuVALL	2a. DATE OF DEATH Month October	Year 1968	2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH May 2, 1883			6. AGE (In years less birthday) 85	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore		
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Caton Ridge Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER 4138 Wilkens Avenue			
14. FATHER'S NAME First Stiers Middle DuVall Last		15. MOTHER'S MAIDEN NAME First Armynella Middle (Unknown) Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) None	17. INFORMANT Mrs. Robert E. Bingel, 4138 Wilkens Ave.	Address 21229			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH D-3 days	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Sangrene left lower extremity (below knee)</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Underlying Cause</u>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4/5 and x</u>							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State	
22a. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from <u>Jan</u> , 19 <u>63</u> , to <u>Oct 1</u> , 19 <u>68</u> , that (I) <input type="checkbox"/> lost saw the deceased alive on <u>Jan 1</u> , 19 <u>68</u> and that in (my) <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (did) <input checked="" type="checkbox"/> view the body after death							
22b. SIGNATURE <u>James J. Nolan</u>	DEGREE <input checked="" type="checkbox"/> MED DIRECTOR	ATTENDING PHYS.	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <u>10/3/68</u>			
22d. PHYSICIAN'S NAME (Type) Dr. James J. Nolan	22e. ADDRESS 1 Mallow Hill Road, Balto., Md.						
23a. BURIAL, CREMATION, REMAINS (Specify) BURIAL	23b. DATE 10-4-1968	23c. NAME OF CEMETERY OR CREMATORIUM Jennings Chapel Cemetery	23d. LOCATION (City or Town) Woodbine, Maryland	(County)	(State)		
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229	ADDRESS	25a. REC'D BY REGISTRAR OCT 4 1968			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



17
Items 4a & 7b Fill in or
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
10/21/68 kk

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

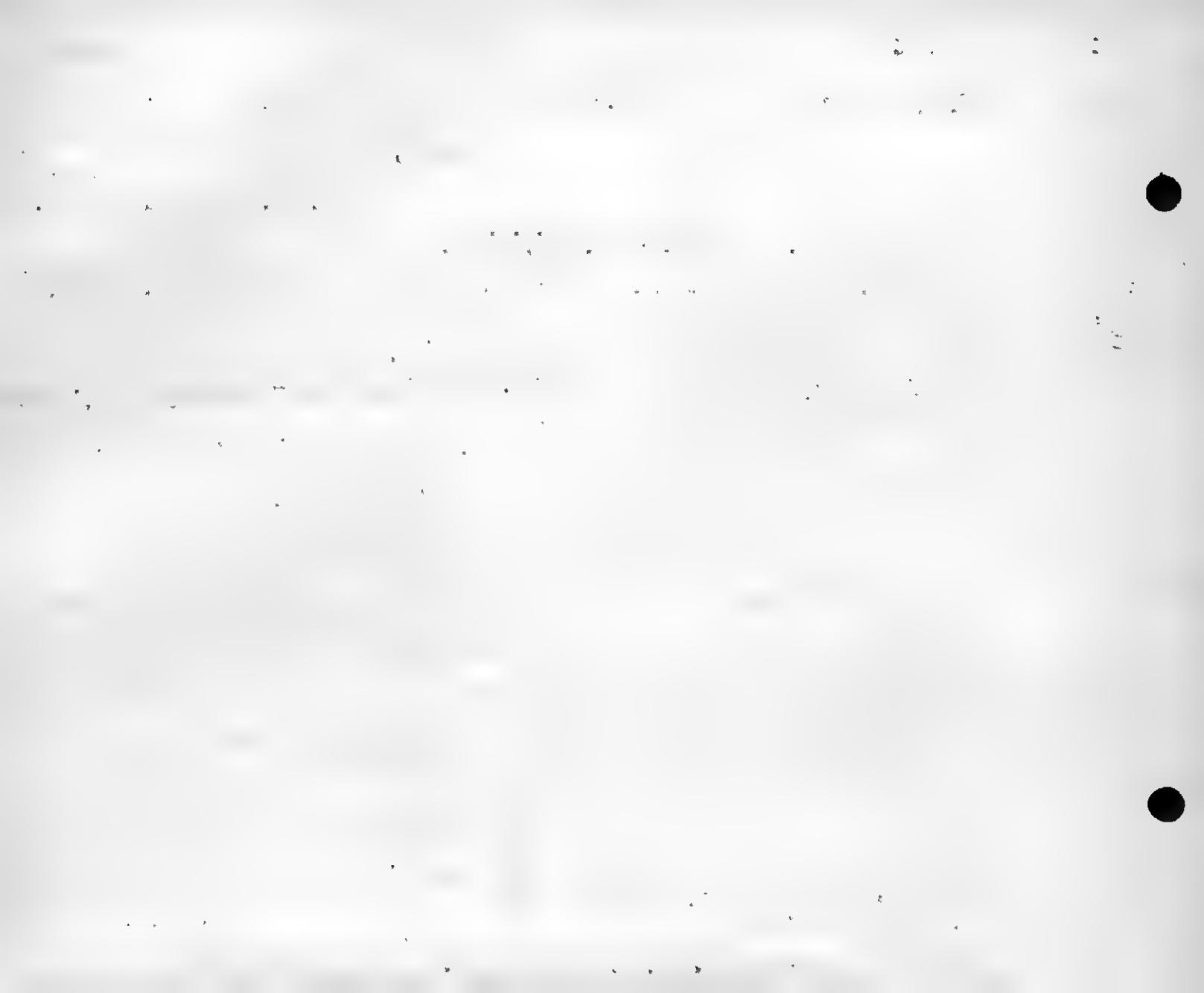
13988

1 DECEASED NAME 13977 Benjamin A Earnshaw			2a. DATE OF DEATH Month Day Year October 14 68	2b. HOUR 1:10 M	
3. SEX M	4. RACE W	S. DATE OF BIRTH July 1, 1916	6. AGE (in years last birthday) 52	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) Washington, DC USA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Balto. Co. Randallstown Md. Md.	21133	
10 CITY OR TOWN OF DEATH Randallstown Md.	11 NAME OF HOSPITAL OR INSTITUTION (if at hospital give street address) Baltimore Co. Gen. Hosp.	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Hearnwood Hgts.	12b KIND OF BUSINESS OR INDUSTRY Hearnwood Hgts.		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.	13b COUNTY Balto.	13c CITY OR TOWN Randallstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 30 Millstone Rd.	
14. FATHER'S NAME JOHN FRANCIS EARNSHAW	15. MOTHER'S MAIDEN NAME LILLIAN GARRETT				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes	16b. SOCIAL SECURITY NO. 214-10-0777	17 INFORMANT Mrs. Patricia Earnshaw	Address 30 Millstone Rd. Hearnwood Hgts. 21133		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute myocardial infarction IMMEDIATE 41 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Atherosclerosis - Endo. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or RFD No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Morton J. Ellin, M.D.		DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c DATE SIGNED 10/14/68
22d. PHYSICIAN'S NAME (Type) Morton J. Ellin, M.D.		22e ADDRESS 8629 Liberty Road, Randallstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE OCT. 16, 68	23c. NAME OF CEMETERY OR CREMATORIAL Lakeview Memorial	23d. LOCATION (City or Town) LIBERTY RD. BALTO. CO. MD.	(County) (State)
24. FUNERAL DIRECTOR Loring Byers 8728 Liberty Rd. Randallstown Md.		ADDRESS		25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE
		DATE OCT 16 1968			

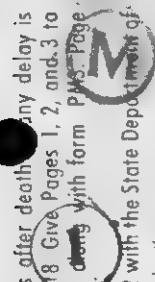
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the physician's arrival.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P.M.C. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13989

1 DECEASED NAME (Type or Print)			First EDWARD	Middle R.	Last EDELBURG	20 DATE KNOWN OF EST. DEATH MATED	Month Oct. 12,	Day 1968	Year 1:45 p.m.	2b HOUR	
3 SEX Male	4. RACE White	5 DATE OF BIRTH Sept. 17, 1907	6 AGE (in years at birthday) 61 yrs	IF UNDER 1 YEAR MONTHS 0	F UNDER 24 HRS DAYS 0	HOURS 0	M.N. 0	2c DATE PRONOUNCED DEAD Month Oct.	Day 12,	Year 1968	2d HOUR 1:45 p.m.
7a BIRTHPLACE (State or foreign country) Illinois	7b CITIZEN OF WHAT COUNTRY? U. S. A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> <input type="checkbox"/> DIVORCED	9 COUNTY OF DEATH Baltimore								
10. CITY OR TOWN OF DEATH Dundalk		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1813 East Ave.			12a US JAL OCCUPATION (Kind of work done during most of working life, even if retired). Retired-Pipefitter-Continental Can			12b KIND OF BUSINESS OR CO. INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b COUNTY Baltimore		13c CITY OR TOWN Dundalk	13d. INSIDE CITY LIM. IS?	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 1813 East Avenue			
14. FATHER'S NAME Edward		Middle Edelburg	Last Edelburg	15 MOTHER'S MAIDEN NAME Caroline	First Caroline	Middle Teffs	Last Teffs				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO 284-09-5074		17 INFORMANT (Step-daughter)	ADDRESS Mrs. Anna Klinger, 4622 O'Donnell St. Balto.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fatty Liver -71.8 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) { stating the <u>underlying cause</u> last (b) { DUE TO, OR AS A CONSEQUENCE OF (c) {											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?		
									YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Christ Lutheran Church		21f LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Edward F. Wilson, M.D.											22b. DATE SIGNED October 13, 1968
EXAMINER'S NAME (Type)											DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county) Baltimore, Maryland
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 10/15/68		23c NAME OF CEMETERY OR CREMATORIUM Christ Lutheran Church			23d LOCATION (City or Town) Baltimore, Maryland		(County) Baltimore, Maryland	(State) Maryland	
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		ADDRESS		25a REC'D BY REGISTRAR OCT 16 1968			25b REGISTRAR'S SIGNATURE Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1397

CERTIFICATE OF DEATH

13990

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium	c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 19 Northwood Drive	d. STREET ADDRESS 19 Northwood Drive				
6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	3. NAME OF DECEASED (Type or print) First Middle Last Ludwig Eger	4. DATE OF DEATH Month Day Year October 20, 1968			
5. SEX Male White	6. COLOR OR RACE WIOOWEOX	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 16, 1909	9. AGE (in years at last birthday) 58 yrs.	10. IF UNDUE 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERVISOR SHIPPING - RET.	10b. KIND OF BUSINESS OR INDUSTRY B. & D. Mfg. Co.	11. BIRTHPLACE (County & State, or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William H. Eger	14. MOTHER'S MAIDEN NAME Mary Koellner	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service) Yes WW II	16. SOCIAL SECURITY NO.	17. INFORMANT Family records	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 4201					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Jesse 10, 1968	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from Oct 20, 1968, to Oct 20, 1968, that (I) (we) last saw the deceased alive on Oct 20, 1968, and that death occurred at 530P.M. from the causes and on the date stated above.	22a. SIGNATURE Laurence P. Post	22b. DATE SIGNED 10/22/68			
22c. PHYSICIAN'S NAME (Type) Laurence P. Post	M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS 6805 York Rd Baltimore Md	M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 23, 1968	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Jessops Cemetery	23d. LOCATION (City, town or county) Cockeysville, Maryland	(State)	
24. FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland	25a. REC'D BY REGISTRAR DATE OCT 24 1968	25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

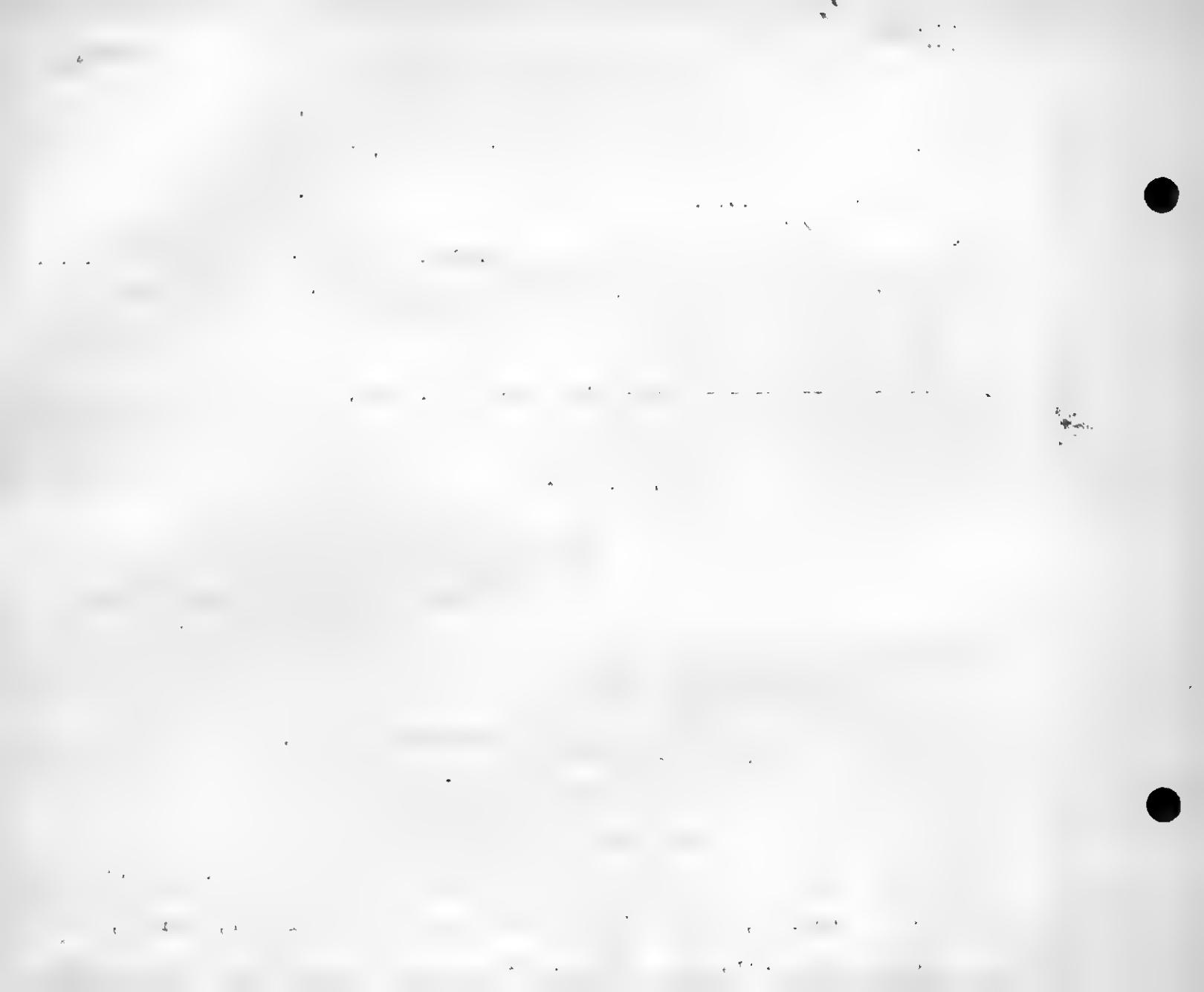
CERTIFICATE OF DEATH

13991

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

1. DECEASED NAME (Type or print)	First MARGARET	Middle IDA	Last EKIN	2a. DATE OF DEATH Month Oct	Doy 8	Year 68	2b. HOUR a 7:55 M				
3. SEX Female	4. RACE White	5. DATE OF BIRTH September 16, 1904			6. AGE (In years last birthday) 86	YRS.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN 0	
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Baltimore,								
10. CITY OR TOWN OF DEATH 21204 Baltimore, Maryland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Baltimore Med. Cet. Homemaker			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY U.S.A.				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Towson	13d. INSIDE CITY LIMIT? YES	13e. STREET AND NUMBER # 540 Valley View							
14. FATHER'S NAME First John	Middle Thomas	Last Roop	15. MOTHER'S MAIDEN NAME First Ida	Middle Lescaleett	Last 						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? No	16b. SOCIAL SECURITY NO (If yes give war or dates of service) 219-20-6643	17. INFORMANT Kenneth H. Ekin,	Address Same as # 13								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Bronchopneumonia						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
2022 Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized malignant lymphoma											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
MEDICAL CERTIFICATION ON <i>X</i>		19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
							YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>	Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. 10 Month Aug. Day 50 Year 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) AT HOME		21f. LOCATION Street or R.F.D. No. Greater Baltimore Medical Center		City or Town Westminster, Carroll, Maryland		County Carroll	State Maryland		
22a. I certify that (I) (this hospital) attended the deceased from Aug. 50, 1968 , to Oct 8, 1968 , that (I) (we) last saw the deceased alive on Oct 8, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Charles C. Brown, M.D.</i>		DEGREE Charles C. Brown, M.D.			ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED 10/8/68			
22d. PHYSICIAN'S NAME (Type) Charles C. Brown, M.D.		22e. ADDRESS Greater Baltimore Medical Center									
23e. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct. 10, 1968		23c. NAME OF CEMETERY OR CREMATORIAL Meadow Branch Cemetery			23d. LOCATION (City or Town) Westminster, Carroll, Maryland		(County) Carroll	(State) Maryland	
24. FUNERAL DIRECTOR <i>Wm. Cook-Brooks</i>		ADDRESS Towson, 1050 York Rd. 21204			25a. REC'D BY REGISTRAR OCT 9 1968			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13981

CERTIFICATE OF DEATH

13992

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED-NAME (Type or print)	First <i>Paul</i>	Middle <i>Phillip</i>	Last <i>Elchenko</i>	2a. DATE OF DEATH Month <i>10</i>	Day <i>8</i>	Year <i>68</i>	2b. HOUR <i>4:45 PM</i>		
3 SEX <i>M</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>2/16/1888</i>		6. AGE (In years last birthday) <i>80</i>	IF UNDER 1 YEAR MONTHS <i>0</i>	DAYS <i>0</i>	HOURS <i>0</i>	MIN <i>0</i>	
7a. BIRTHPLACE (State or foreign country) <i>Russia</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>Baltimore</i>						
10 CITY OR TOWN OF DEATH <i>CATONSVILLE</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>1409 Frederick Rd</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>NIGHT WATCHMAN</i>			12b KIND OF BUSINESS OR INDUSTRY <i>STATE of Md.</i>		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>	13b COUNTY <i>Baltimore</i>	13c CITY OR TOWN <i>CATONSVILLE</i>	13d INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>1409 Frederick Rd</i>					
14. FATHER'S NAME First <i>Philip</i>	Middle <i></i>	Last <i>Elchenko</i>	15 MOTHER'S MAIDEN NAME First <i>?</i>	Middle <i></i>	Last				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, unknown <i>No</i>	16b. SOCIAL SECURITY NO. <i>28501-37464</i>	17 INFORMANT <i>Mrs Glenn D. Steele</i>	Address <i>1409 Frederick Rd</i>						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of gall bladder with metastasis</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 months +</i>				
DUE TO, OR AS A CONSEQUENCE OF (b) _____ stating the underlying cause lost (c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>100</i>									
19a. DATE OF OPERATION <i>10/2/68</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <small>If either, notify medical examiner</small>	21b TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>OFFICE BUILDING, ETC.</i>	21f. LOCATION Street or R.F.D. No <i>1009 Frederick Rd</i>	City or Town <i>Baltimore</i>	County <i>Baltimore</i>	State <i>Md</i>				
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 8</i> , 1968, to <i>Oct 8</i> , 1968, that (I) (we) last saw the deceased alive on <i>Oct 8</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>John A. Nesbitt Jr MD</i>	DEGREE <i>MD</i>	ATTENDING PHYS <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED <i>10-8-68</i>						
22d. PHYSICIAN'S NAME (Type) <i>JOHN A. NESBITT, JR</i>	22e ADDRESS <i>1009 Frederick Rd, Baltimore</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>10/11/68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Loudon PK</i>	23d. LOCAT ON (City or Town) <i>Baltimore</i>	(County) <i>Baltimore</i>	(State) <i>Md</i>				
24. FUNERAL DIRECTOR <i>Charles Nabb</i>	ADDRESS <i>301 Frederick Rd</i>	25a. REC'D BY REGISTRAR DATE <i>OCT 14 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Nabb</i>						



Item 13 Film 3406 11/6/68 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13982

CERTIFICATE OF DEATH

13993

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)	First Mary	Middle Hubert Cowan	Last Ennis	2a. DATE OF DEATH Month October	Day 27	Year 1968	2b. HOUR M
3. SEX Female	4 RACE White	5. DATE OF BIRTH April 12, 1878			6. AGE (in years last birthday) 90	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Delaware	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Baltimore				
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Towson Convalescent Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Towson	13d. INSIDE CITY LIMIT YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	14. STREET AND NUMBER 912 Delaney Valley Road	13e. STREET AND NUMBER 301 W. Chesapeake Ave.		
14. FATHER'S NAME Andrew	First S.	Middle Cowan	Last	15. MOTHER'S MAIDEN NAME Mary	Middle G.	Last Hubert	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO (If yes give war or dates of service) 220-46-9918	17. INFORMANT Mr. Dawson L. Farber Jr.	Address 614 Chesnut Ave.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Osteo sclerotic cardiac vascular disease</i> 10 yrs DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Unicocular fibrillation</i> 10 yrs DUE TO, OR AS A CONSEQUENCE OF (c) <i>Congestive heart failure</i> 3 days							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4/11 <i>Generalized osteoarthritis</i>							
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>60</u> , to <u>27 Oct</u> , 19 <u>68</u> , that (I) (<input checked="" type="checkbox"/> my) lost soul the deceased alive on <u>25 Oct</u> 19 <u>68</u> , and that in (my) (<input checked="" type="checkbox"/> her) opinion death occurred on the date and hour and from the causes stated above, (I) (<input checked="" type="checkbox"/> my) (<input checked="" type="checkbox"/> did) (did not) view the body after death.							
22b. SIGNATURE <i>Ernest S. Cross Jr.</i>		22c. DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22d. DATE SIGNED 28 Oct '68			
22d. PHYSICIAN'S NAME (Type) Ernest S. Cross Jr.		22e. ADDRESS 803 MED. ARTS. Bldg.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/29/68	23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cemetery			23d. LOCATION (City or Town) Baltimore, Maryland	(County)	(State)
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson 1050 York Rd. 21204	ADDRESS			25a. REC'D BY REGISTRAR OCT 30 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	DATE	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

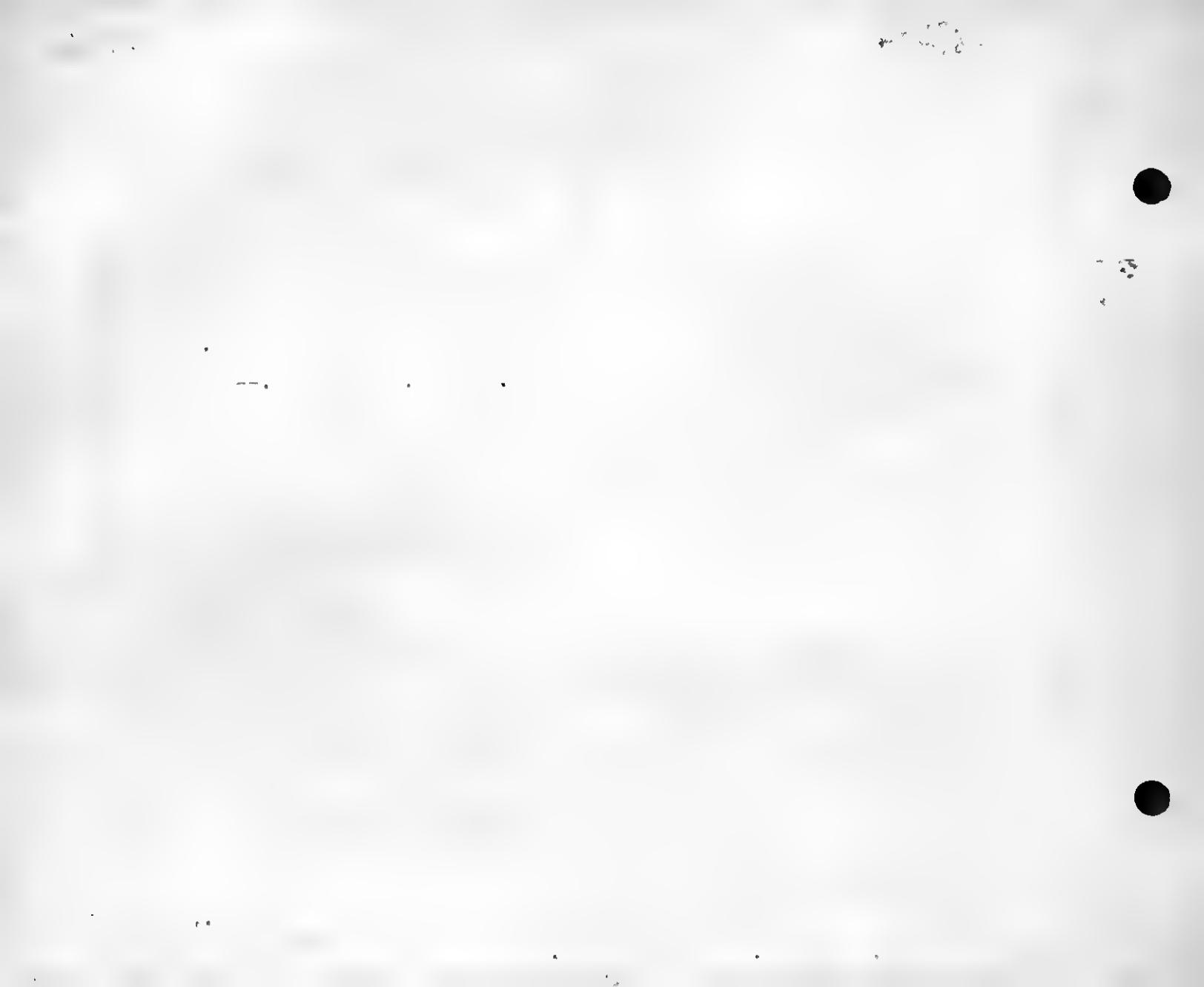
13994

1. DECEASED-NAME (Type or print)			First	Middle	Lost	20. DATE OF DEATH	2b. HOUR
JOHN HOWARD JR. ERDMAN						Month 10 Doy 9 Year 68	9:30 PM
3. SEX	4. RACE	S. DATE OF BIRTH			6. AGE (in years last birthday) 6 mo yrs.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male	CAucasian	3-18-68			6 mo yrs.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
BALTO, MD		USA				BALTIMORE	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY
BALTIMORE		G. B. M.C.			None		None
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
MD.		BALTO.		BALTO.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	2705 Fleetwood Ave	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME	LAST	MIDDLE
JOHN		H.	ERDMAN		CROWTHER	J.	CAROLYN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address	
No		None		Mr. John H. Erdman, Sr.--		Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac insufficiency failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 2750 <i>hypertensive failure</i> (b) <i>hypertensive failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>post. cystic fibrosis</i>							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) None							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION	Street or R.F.D. No.	City or Town	County State
22o. I certify that (I) (this hospital) attended the deceased from <i>10/6/68</i> , to <i>10/17/68</i> , that (I) (we) last saw the deceased alive on <i>10/17/68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>A. F. NELZ</i>		DEGREE	ATTENDING PHYS	<input type="checkbox"/> MED. DIRECTOR	<input checked="" type="checkbox"/> STAFF PHYS	22c. DATE SIGNED <i>10/19/68</i>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <i>G. B. M.C.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 10/11/68	23c. NAME OF CEMETERY OR CREMATORIAL Moreland Cemetery		23d. LOCATION (City or Town) Baltimore Co., Maryland	(County) (State)	
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd. 21214		ADDRESS	25a. REC'D. BY REGISTRAR DATE OCT 11 1958		25b. REGISTRAR'S SIGNATURE <i>Charles J. Ruck</i>		

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A 5
30M REV



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

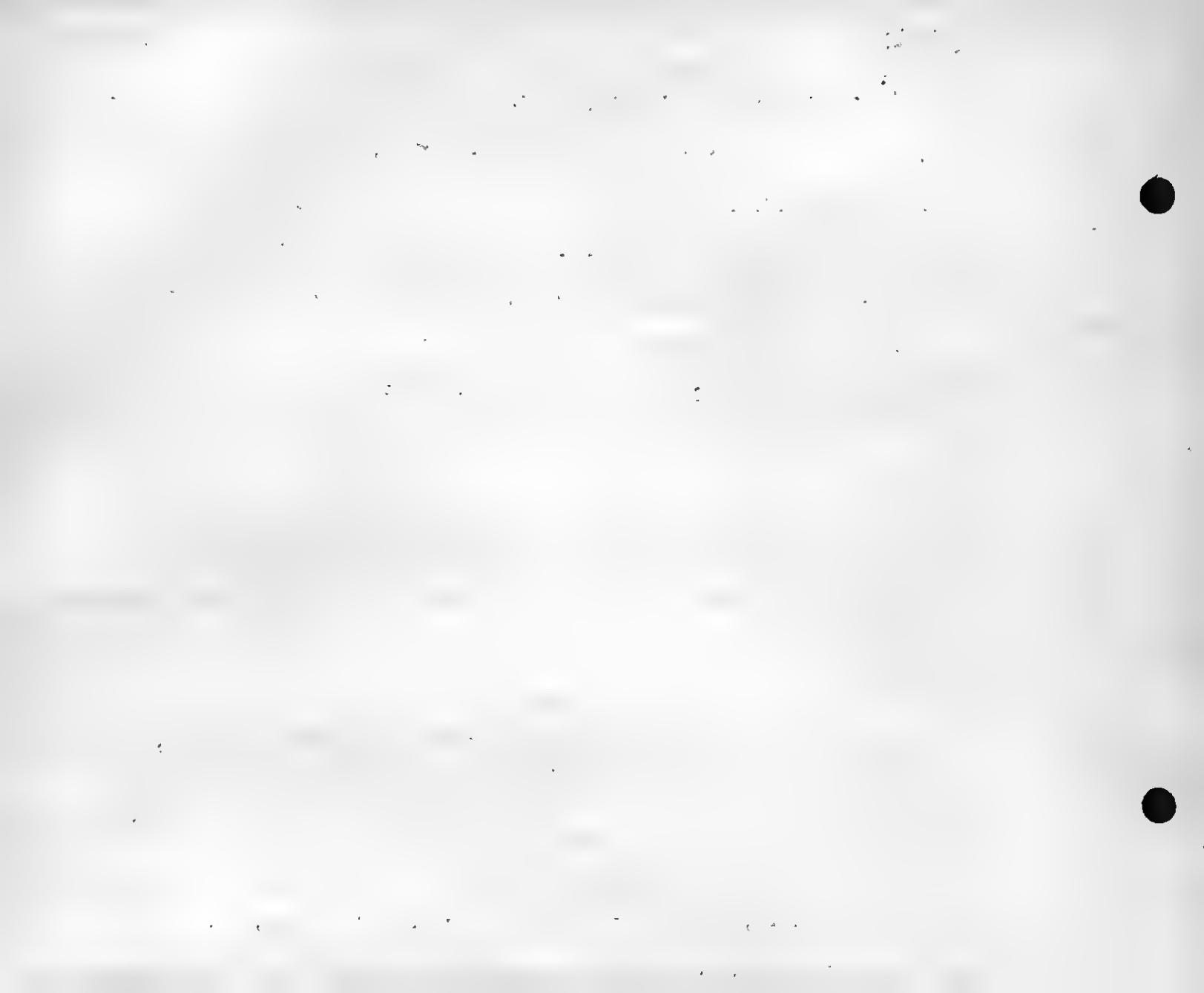
13984

13995

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or the attending physician's director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First GETTINGS	Middle WILLIAM	Last ERNEST	2a. DATE OF DEATH Month 10	Day 26	Year 68	2b. HOUR 5:05A
3. SEX MALE	4. RACE Cau.	5. DATE OF BIRTH November 30, 1903		6. AGE (In years last birthday) 64	YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	B MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH BALTIMORE				
10. CITY OR TOWN OF DEATH TOWSON	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) G.B.M.C.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) SHIP PILOT		12b. KIND OF BUSINESS OR INDUSTRY Md.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Baltimore	13c. CITY OR TOWN Towson	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 730 Charing Terrace			
14. FATHER'S NAME Charles William Ernest	15. MOTHER'S MAIDEN NAME Annie						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO. 215-32-9698	17. INFORMANT Agnes F. Ernest, Same as # 13	Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>EXTENSIVE METASTATIC CA SPINE</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
1702 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
(b) DUE TO, OR AS A CONSEQUENCE OF							
(c) DUE TO, OR AS A CONSEQUENCE OF							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>10/20</u> , 19 <u>68</u> , to <u>10/26</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>10/26</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Neeraja Thakur</u>		DEGREE ATTENDING PHYS	<input type="checkbox"/>	MED DIRECTOR	<input type="checkbox"/>	STAFF PHYS	<input type="checkbox"/>
22d. PHYSICIAN'S NAME (Type) NEERAJA THAKUR, M.D.		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct. 29, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Lorraine Park Cemetery		23d. LOCATION (City or Town) Woodlawn, Md.	(County)	(State)
24. FUNERAL DIRECTOR Wm. Cook-Brooks		ADDRESS Towson, 1050 York Rd., Towson		25a. REC'D BY REGISTRAR OCT 29 1968	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13985

13996

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours of the death.

1. DECEASED NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH Month	10	2b. HOUR AM.				
<u>SALLIE R. ESSIG</u>					15	60	55				
3. SEX		4. RACE		5. DATE OF BIRTH	<u>3/29/95</u>		6. AGE (In years last birthday) <u>73</u> YRS.				
<u>F</u>		<u>W</u>					IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. HOURS	MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. COUNTY OF DEATH					
<u>Md</u>		<u>U.S.</u>		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<u>BALTO</u>					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USJAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
<u>CATONSVILLE</u>		<u>SHAFER WORK</u>			<u>HOUSEWIFE</u>						
13a. USJAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMIT?	13e. STREET AND NUMBER					
<u>Md</u>		<u>BALTO</u>		<u>CATONSVILLE</u>	<input type="checkbox"/>	<u>1000 MAGRUDER AVE</u>					
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME	First	Middle	Last			
<u>JOHN RENEHAN</u>					<u>MARY HENNESSY</u>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address					
(If yes give war or dates of service)						<u>MRS MARY E. KERGER</u>					
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Toxic hepatitis</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>arteriosclerotic hypertension cardiovascular</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
					<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County	State		
22a. I certify that (I) (this hospital) attended the deceased from <u>June 20</u> , 19 <u>67</u> , to <u>Oct. 15</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Oct 14</u> 19 <u>65</u> , and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (<u>did</u>) (did not) view the body after death.											
22b. SIGNATURE <u>John A. Nesbitt Jr.</u>		DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <u>10-16-68</u>					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			23d. LOCATION (City or Town) (County) (State)						
<u>John A. Nesbitt, Jr.</u>		<u>1009 Frederick Road</u>			<u>BALTO</u> <u>Md</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION (City or Town)		(County)		(State)
<u>BURIAL</u>		<u>10/17/68</u>		<u>CATHEDRAL</u>			<u>BALTO</u>				
24. FUNERAL DIRECTOR		ADDRESS			25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
<u>E.S. MACNABB</u>		<u>21028</u>			DATE <u>OCT 18 1968</u>		<u>Charles Judge</u>				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

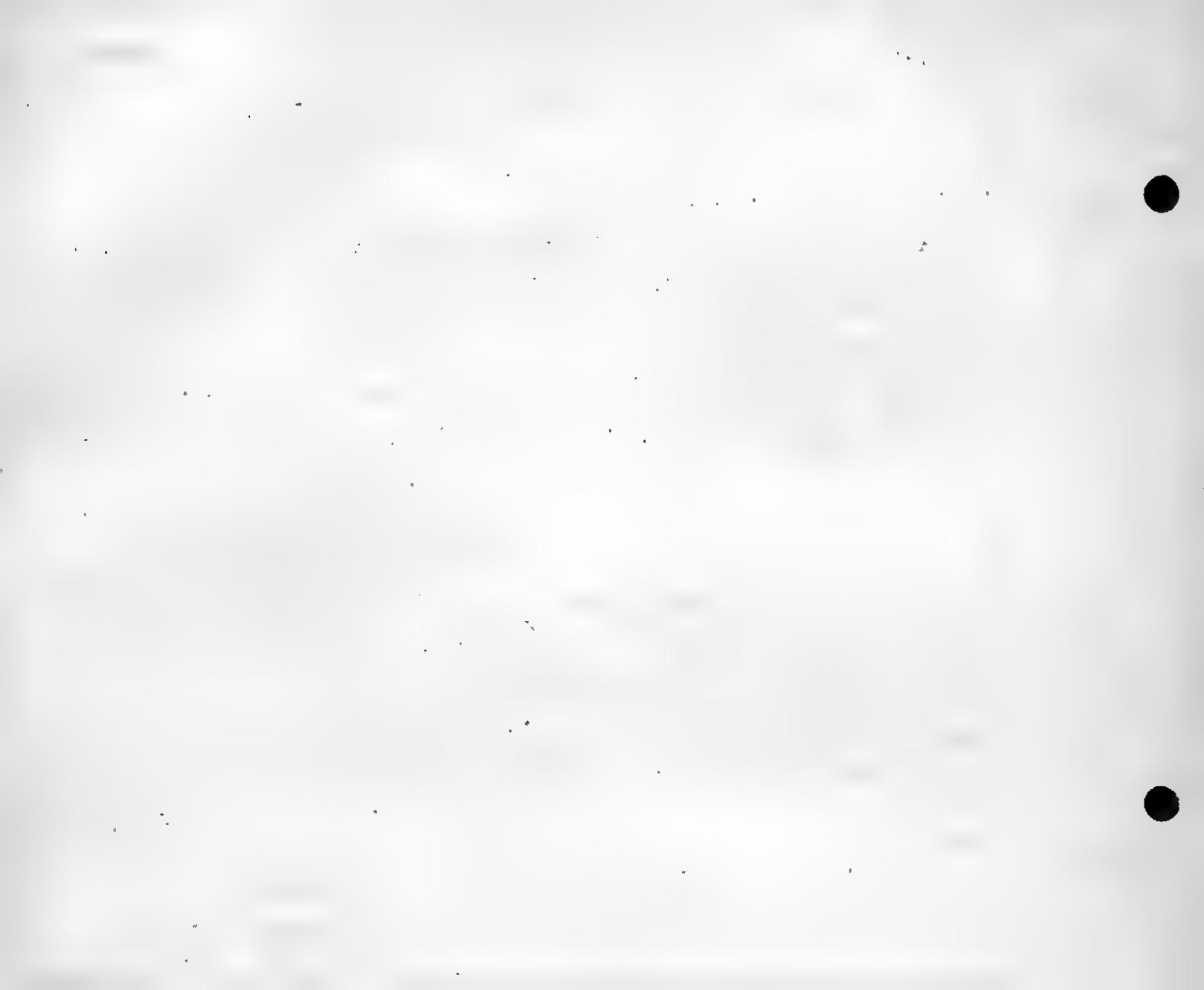
CERTIFICATE OF DEATH

13986

13997

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First JOHN	Middle E.	Last EWING	2a. DATE OF DEATH October Month 18 Year 1968	2b. HOUR 8:30 M
3. SEX Male	4. RACE White	5. DATE OF BIRTH Sept. 17, 1915		6. AGE (In years last birthday) 55	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore		
10. CITY OR TOWN OF DEATH Dundalk	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 6746 Woodley Road		12a. USIAL OCCUPATION (Kind of work done during most of working life, even if retired) Leader		12b. KIND OF BUSINESS OR INDUSTRY Welding rods
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Dundalk	13d. INSIDE CITY LIMIT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 6746 Woodley Road	
14. FATHER'S NAME First James	Middle Ewing	Last	15. MOTHER'S MAIDEN NAME First Dorothy	Middle	Last Ohler
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	16b. SOCIAL SECURITY NO. 212-18-3073	17. INFORMANT Mrs. Vera Ewing, 6746 Woodley Road	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Coronary Occlusion 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) A-S-C-V Disease DUE TO, OR AS A CONSEQUENCE OF (c)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING □ CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from Oct. 17, 1968 , to Oct. 18, 1968 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on Oct. 17, 1968 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did not) <input type="checkbox"/> view the body after death.					
22b. SIGNATURE M.B. Davis M.D.					
22d. PHYSICIAN'S NAME (Type) M.B. Davis, M.D.		22e. ADDRESS 6800 Mornington Road. - 21222	22c. DATE SIGNED 10/20/68		
23c. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Oct. 21, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Cemetery	23d. LOCATION (City or Town) Woodlawn, Md.	(County)	(State)
24. FUNERAL DIRECTOR Ulrich Funeral Home Dundalk, Md.	ADDRESS	25a. REC'D BY REGISTRAR DATE OCT 25 1968	25b. REGISTRAR'S SIGNATURE Charles J. Ulrich		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

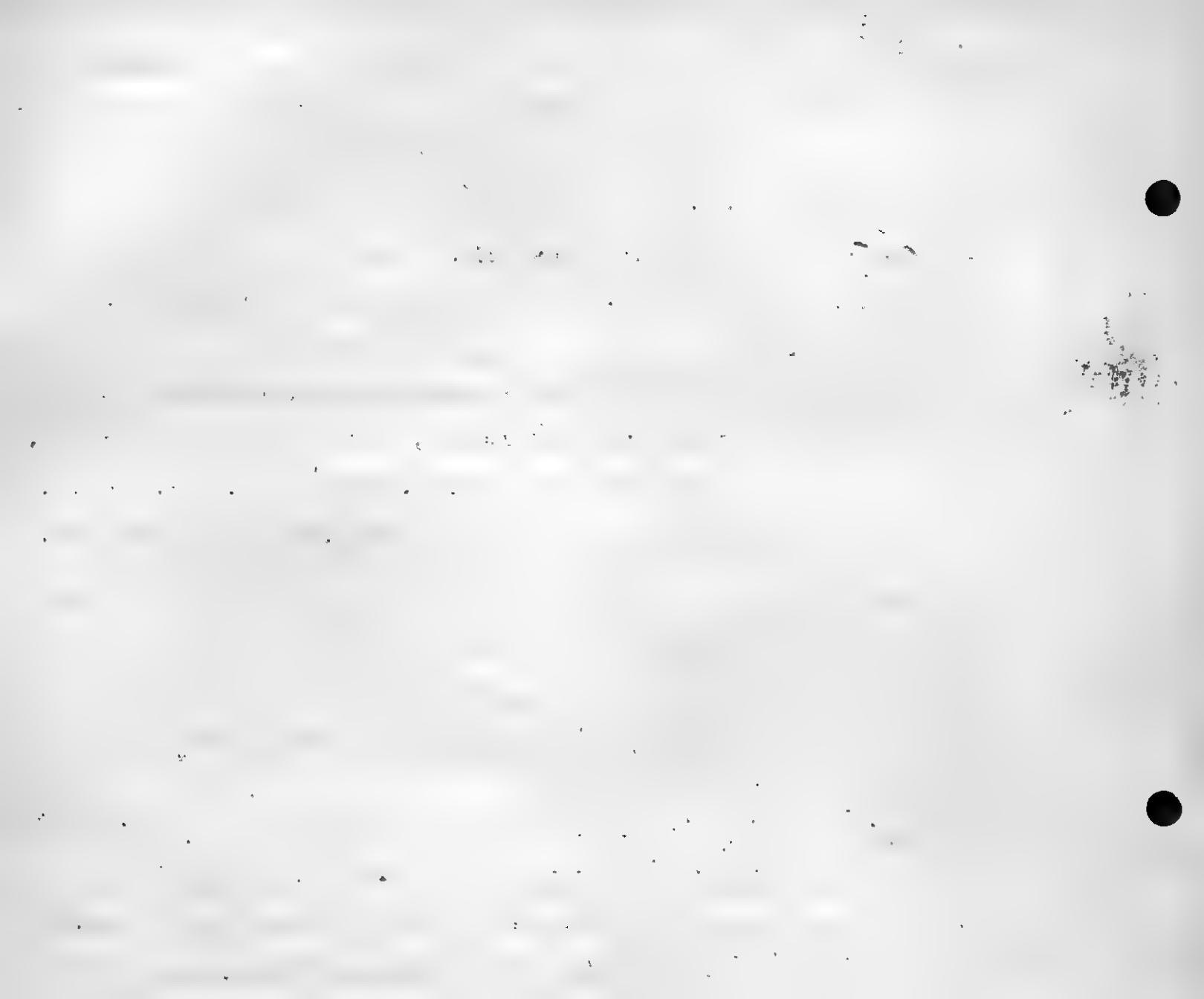
13S87

13998

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers page 2 and 3. The funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers page 2 and 3. This certificate, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First <i>Annie</i>	Middle <i>Fairchild</i>	Last <i>Fairchild</i>	2a. DATE OF DEATH Month <i>October</i>		Day <i>1, 1968</i>	Year <i>1968</i>	12b. HOUR <i>4:20 P.M.</i>	
3. SEX female		4. RACE white		S. DATE OF BIRTH <i>July 27, 1877</i>	6. AGE (In years last birthday) <i>91</i>		7. IF UNDER 1 YEAR MONTHS <i>0</i>		8. IF UNDER 24 HRS HOURS <i>0</i>	
7a. BIRTHPLACE (State or foreign country) Missouri		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore					
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) SPRING GROVE STATE HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13c. CITY OR TOWN Oxon Hill		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 5119 Dumbries St.					
14. FATHER'S NAME First Thomas Harrison		Middle <i></i>	Last <i></i>	15. MOTHER'S MAIDEN NAME First Elijah		Middle <i>UNKNOWN</i>	Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. (If give war or dates of service) 212-56-2381		17. INFORMANT J. I. Records: SPRING GROVE STATE HOSPITAL		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Myocardial Infarction, acute, death				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours.				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause 		DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic Cardiovascular Ht. Dis.		10 yrs.						
DUE TO, OR AS A CONSEQUENCE OF (b) 		(c) Arteriosclerosis, Generalized, Senile		10 yrs.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Dec. 20, 1967 , to Oct. 1, 1968 , that <input checked="" type="checkbox"/> (I) (<input checked="" type="checkbox"/> he) last saw the deceased alive on Oct. 1, 1968 , and that in <input checked="" type="checkbox"/> (my) (<input checked="" type="checkbox"/> her) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (I) (<input checked="" type="checkbox"/> he) (did) <input checked="" type="checkbox"/> (did not) view the body after death.										
22b. SIGNATURE <i>Anthony J. Young, M.D.</i>		DEGREE <i>M.D.</i>	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>10/19/68 5:00 P.M.</i>				
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-4-68		23c. NAME OF CEMETERY OR CREMATORIUM Ft. Lincoln Cem		23d. LOCATION (City or Town) Colmar Manor Md.		(County) 	(State) 	
24. FUNERAL DIRECTOR W.W. Chamber Co.		ADDRESS 8655 Ft. Ave. Silver Spring Md.		25a. REC'D BY REGISTRAR DA OCT 4 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13988

13999

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 DECEASED NAME (Type or print)	First Hanson	Middle (Fauntleroy)	Last Fauntleroy	2a DATE OF DEATH Month 10	Doy 9	Year 68	2b HOUR A.M. 2:30 M
3. SEX: Male	4. RACE Negro	5. DATE OF BIRTH 8/28/05			6. AGE (in years last birthday) 63	F UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Baltimore				
10 CITY OR TOWN OF DEATH Baltimore		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital (give street address)) Greater Balt. Med. Center			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Baltimore	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER 1550 Richland Street			
14. FATHER'S NAME First Unk.	Middle	Last	15. MOTHER'S MAIDEN NAME First Lottie Ann Fauntleroy			Middle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16b. SOCIAL SECURITY NO. 212-03-7445	17. INFORMANT Mrs. Mary G. Fauntleroy	Address 1550 Richland Street				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Abdominal carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of pancreas</u> DUE TO, OR AS A CONSEQUENCE OF (c)							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION 15/17		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from 9/23, 1968, to 10/9, 1968, that (I) (we) last saw the deceased alive on 10/9, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Rudiger Breitenecker</i>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 10/9/68		
22d. PHYSICIAN'S NAME (Type) Rudiger Breitenecker, M.D.		22e. ADDRESS 6701 N. Charles Street					
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE 10-12-68	23c. NAME OF CEMETERY OR CREMATORIAL Mount Auburn Cem.		23d. LOCATION (City or Town) Baltimore, Maryland	(County)	(State)
24. FUNERAL DIRECTOR 44-21-24 W 1701 Laurens St.		ADDRESS		25a. REC'D BY REGISTRAR OCT 11 1968	25b. REGISTRAR'S SIGNATURE <i>Charles J. Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13985

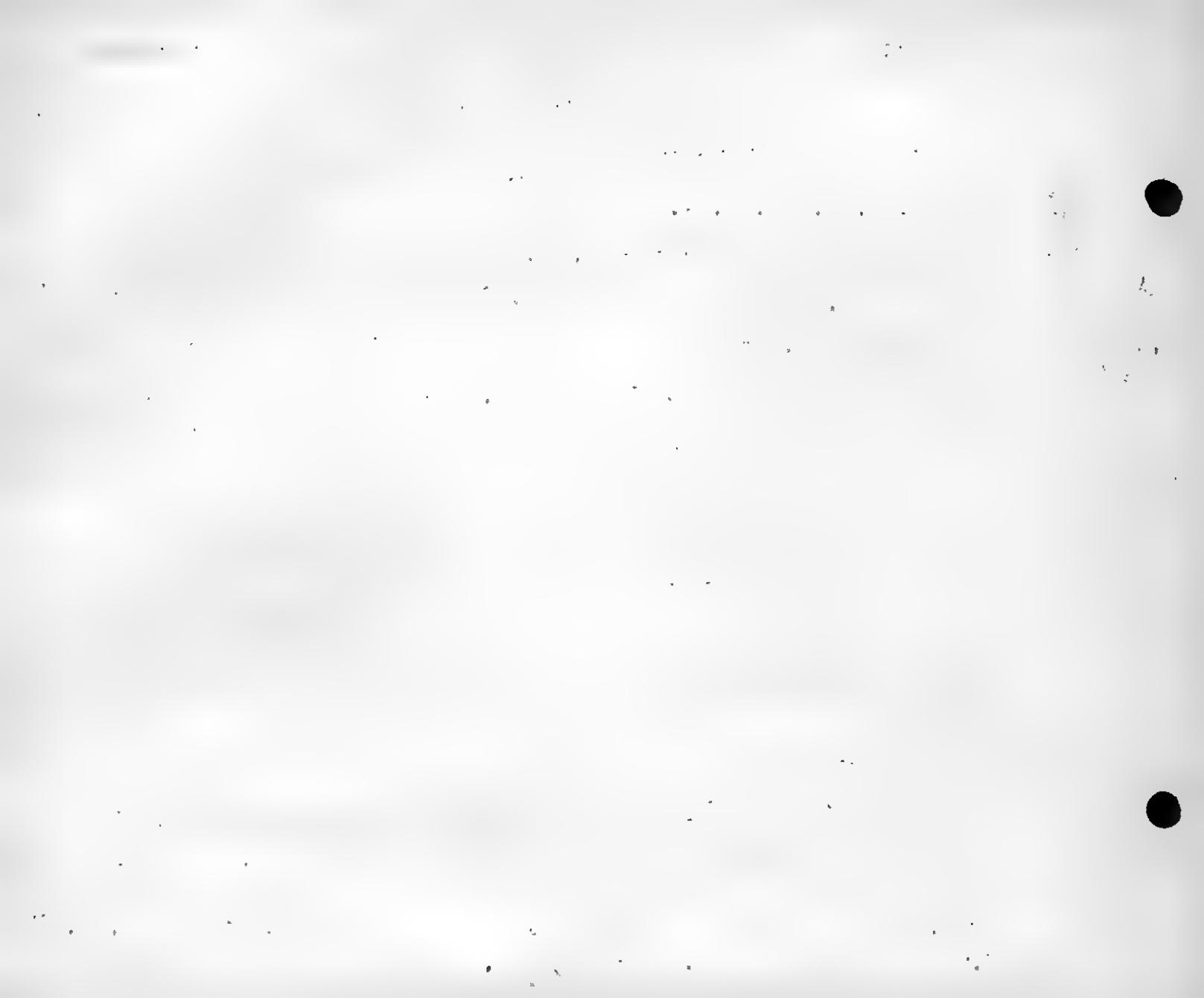
CERTIFICATE OF DEATH

14000

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)	First ALEXANDER	Middle LITTLEJOHN	Last FEILD	2a. DATE OF DEATH Month 10	Doy 10	Year 1968	2b. HOUR :10am	
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH 11/14/1890			6. AGE (In years lost birthday) 77 yrs.			
7a. BIRTHPLACE (State or foreign country) Oxford, N. C.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore					
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balt. Med. Center			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Metalurgist Armco			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.	13b. COUNTY Balto. 12	13c. CITY OR TOWN Balto. 12	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 218 Goodale Road				
14. FATHER'S NAME Alexander J. Feild	First Middle Last	15. MOTHER'S MAIDEN NAME Louise	Middle Hughes			Last		
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO 218-01-6300	17. INFORMANT Mrs. Ethel McKeel Feild	Address (Same)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease 410 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 443 X Laennec's cirrhosis								
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.			City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from 10/3, 1968, to 10/10, 1968, that (I) (we) last saw the deceased alive on 10/10, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Rudiger Breitenecker</i>								
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS Greater Baltimore Medical Center			22c. DATE SIGNED 10/10/68			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/12/68	23c. NAME OF CEMETERY OR CREMATORIALY Druid Ridge			23d. LOCATION (City or Town) (County) (State) Pikesville Balto. Co., Md.		
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Rd. Balto. 12, Md.			25a. REC'D BY REGISTRAR DATE OCT 11 1968			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 6 Film 645

CERTIFICATE OF DEATH

14001

13893

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, file it with the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon paper and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First <i>Elisabeth</i>	Middle <i>C.</i>	Last <i>Fischer</i>	2a. DATE OF DEATH Oct Month 3 Day 1968	2b. HOUR M
3. SEX <i>female</i>	4. RACE <i>white</i>	5. DATE OF BIRTH <i>Oct. 14, 1876</i>		6. AGE (In years last birthday) <i>91 1/2</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>Germany</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>Baltimore</i>	Md.	
10. CITY OR TOWN OF DEATH <i>Woodlawn</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>5505 Windsor Mill Rd.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <i>Maryland</i>	13b. COUNTY <i>Baltimore</i>	13c. CITY OR TOWN <i>Woodlawn</i>	13d. INSIDE CITY LIMIT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER <i>5505 Windsor Mill Rd.</i>	
14. FATHER'S NAME First <i>Johannes</i>	Middle <i>Ulrich</i>	Last	15. MOTHER'S MAIDEN NAME First <i>Babetta</i>	Middle	Last <i>Ulrich</i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? <i>no</i>	16b. SOCIAL SECURITY NO. <i>---</i>	17. INFORMANT <i>Mrs. Fredia H. Fischer, 5505 Windsor Mill Rd.</i>	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause { iast.			1 hour		
(b) <i>Arteriosclerotic cardiovascular disease</i>			15 years		
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
4201		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
MEDICAL CERTIFICATION		19a. DATE OF OPERATION	20c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. LOCATION Street or R.F.D. No.	City or Town	County
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No.	City or Town	County
22a. I certify that (1) this hospital attended the deceased from _____, 19____, to October, 19____, that (1) (we) last saw the deceased alive on August 30, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>M.T. Traband</i>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 10/4/68
22d. PHYSICIAN'S NAME (Type) NAME (Type) <i>M.T. Traband, Jr.</i>		M.D.	22e. ADDRESS <i>1811 N. Rolling Rd. Balt. Md. 21207</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>Oct. 5, 1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Loudon Park</i>	23d. LOCATION (City or Town) <i>Baltimore</i>	(County) <i>Md.</i>	(State)
24. FUNERAL DIRECTOR <i>John T. Stansbury, Sr.</i>	ADDRESS <i>6411 Windsor Mill Rd.</i>	25a. REC'D BY REGISTRAR DATE <i>OCT 7 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

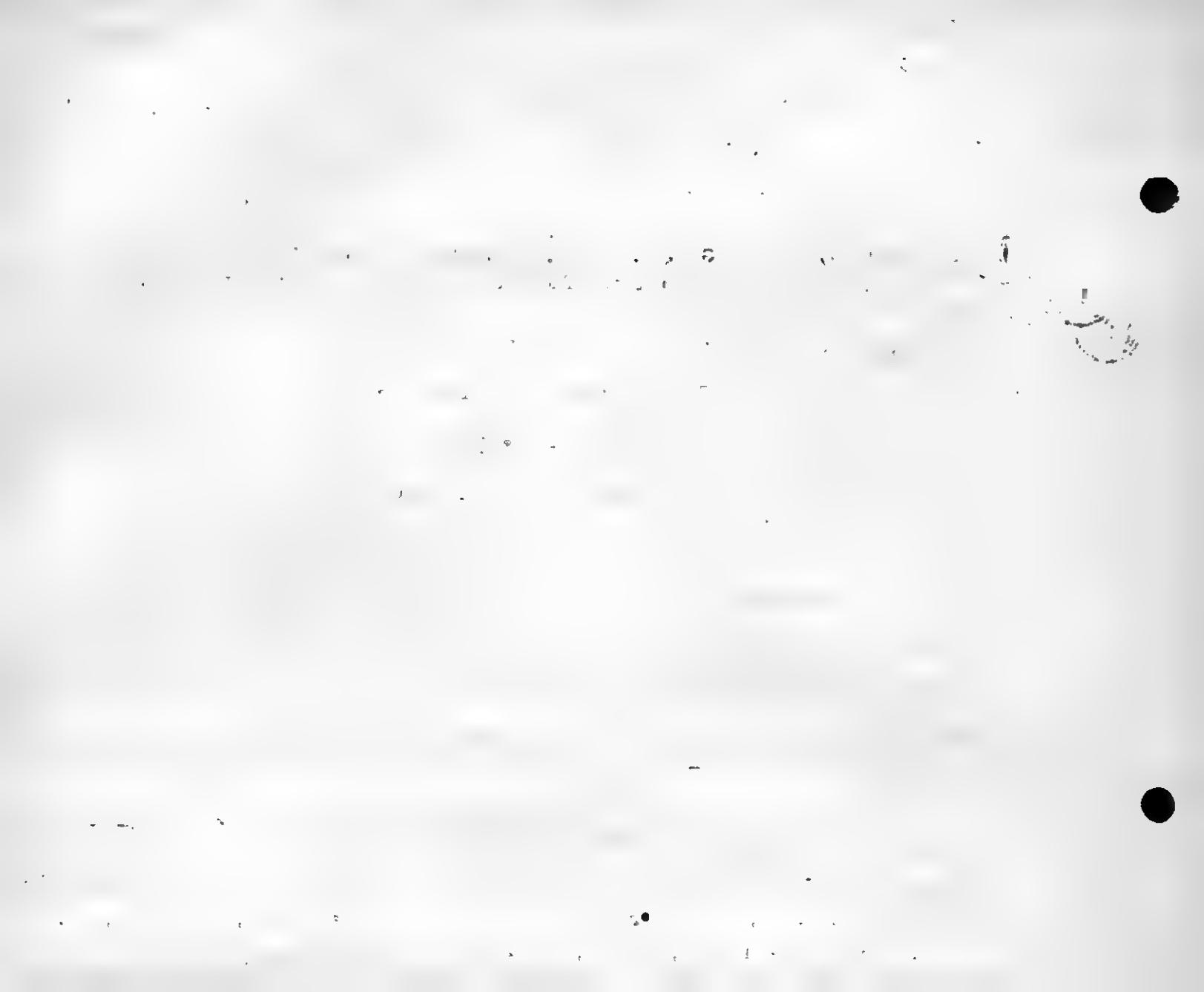
13992

14002

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be filed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. If you do not have a carbon paper, you may file this certificate with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First NELLIE H.	Middle FISHER	Lost	2a. DATE OF DEATH Month 10	Day 8	Year 68	2b. HOUR 10:35 P.M.	
3. SEX female	4. RACE CAU	S. DATE OF BIRTH 11-3-1889	6. AGE (In years last birthday) 78RS	F. UNDER 1 YEAR MONTHS 0	DAYS 0	HOURS 0	IF UNDER 24 HRS MIN. 0	
7a. BIRTHPLACE (State or foreign country) Frederick Co.	7b. CITIZEN OF WHAT COUNTRY? Md. U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE					
10. CITY OR TOWN OF DEATH BALTIMORE, MD	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GREAT. BALT. MED CEN.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Baltimore	13c. CITY OR TOWN Timonium	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 225 Chantry Rd.				
14. FATHER'S NAME Champe Mauzey	15. MOTHER'S MAIDEN NAME Katherine Hilliery					Middle	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. 710 09 5900	17. INFORMANT Hospital Records	Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
MEDICAL CERTIFICATION		19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
		21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
		21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from 10-7 , 19 68 to 10-8 , 19 68 , that (I) (we) last saw the deceased alive on 10-8 , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>DR. YEH</i>				DEGREE DR.	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input checked="" type="checkbox"/>	22c. DATE SIGNED 10-8-68
22d. PHYSICIAN'S NAME (Type) DR. YEH				22e. ADDRESS 6701 N CHARLES ST BALT. MD				
23a. BURIAL, CREMATION, REMOVAL Bureau		23b. DATE Oct. 12, 68	23c. NAME OF CEMETERY OR CREMATORIAL Moreland			23d. LOCATION (City or Town) Baltimore	(County) Baltimore, Md.	(State)
24. FUNERAL DIRECTOR Wm. Cook-Brooks		ADDRESS Towson, Md. 21204	25a. REC'D BY REGISTRAR DATE OCT 10 1968			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14003

13993

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First DOROTHY (DORA)	Middle FLAX	2a. DATE OF DEATH Month OCTOBER	Day 27	Year 1968	2b. HOUR 10 A.M.		
3. SEX FEMALE	4. RACE WHITE	S. DATE OF BIRTH OCTOBER 31, 1907	6. AGE (In years last birthday) 60 YRS.					
7a. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE	
10. CITY OR TOWN OF DEATH Pikesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) PROFESSIONAL HOUSE	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) EXECUTIVE				12b. KIND OF BUSINESS OR INDUSTRY CHILDRENS WEAR	
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE MARYLAND		13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES		13e. STREET AND NUMBER 6600 VINCENT LANE			
14. FATHER'S NAME First BARNET	Middle WEINSTEIN	Last ALTA	15. MOTHER'S MAIDEN NAME First GERSUK					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT MRS. PATRICIA RUDIE, 3204 WOODVALLEY DR. # 8	Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Ventricular fibrillation				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour		
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.		Rheumatic Heart Disease				41 years		
(b)		+ atricular fibrillation						
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 416.								
19a. DATE OF OPERATION 416.	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from Oct 25, 1968 to Oct 27, 1968 , that (I) (we) last saw the deceased alive on Oct 27, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Leonard Wallenstein	DEGREE ATTENDING PHYS	22c. DATE SIGNED 10/28/68	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS				
22d. PRINTS CLAN'S NAME (Type) LEONARD WALLSTEIN	22e. ADDRESS 848 W. 36th STREET							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 10-28-68	23c. NAME OF CEMETERY OR CREMATORIAL KNESSETH ISRAEL ANSHE KOKH	23d. LOCAT ON (City or Town) WOLYN, BALTIMORE, MARYLAND	(County)	(State)			
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	ADDRESS	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE					
DATE OCT 30 1968								



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. Any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form M-3 which may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1393 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14004

1. DECEASED-NAME (Type or Print)		First	Middle	Lost	20. DATE KNOWN OF ESTI- DEATH MADE	Month	Day	Year	2b. HOUR
		JOHN JOSEPH		FLINT	<input checked="" type="checkbox"/>	10	12	168	1:00a
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONONCED DEAD Month Day Year			2d HOUR
Male	White	6-29-48	20 YRS			October	12	1968	1:00a
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		USA				Baltimore			Md.
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY	
Balto.		Balto. Co. Gen. Hospital			SERVICE STATION			ESSO	
13a USUAL RESIDENCE (Where deceased lived, if institu- on Reside before admission) STATE		13b. COUNTY		13c CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e STREET AND NUMBER		
Md.		BALTO.		Balto.	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		5926 Prince George Ave.		
14. FATHER'S NAME		First	Middle	Lost	15 MOTHER'S MAIDEN NAME		First	Middle	Lost
JOSEPH G. FLINT					MARIE GAYNHARD				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16b SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
NO		219-50-0643		JOSEPH G. FLINT		5426 PRINCE GEORGE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART I. DEATH WAS CAUSED BY									
IMMEDIATE CAUSE (a) <u>Multiple traumatic injuries</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____									
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?					
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR AM PM		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
11:01PM		10 12 68		Subject driver in auto-fixed object coll.					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street		21f LOCATION street or R.F.D. No City or Town County State					
				Dogwood Rd. past Hollofield Rd. Daniels, Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED October 12, 1968		
EXAMINER'S NAME (Type)									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City or Town)		(County) (State)	
BURIAL		10-15-68		LORRAINE PARK CEM		BALTO		MARYLAND	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
Edward F. Weber		WEBER FUNERAL HOME 5311 EL MONDONSON AVE		OCT 14 1968		Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14005

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, file the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

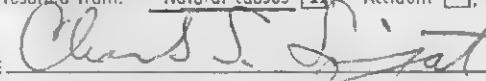
1 DECEASED NAME (Type or print)	First ARTHUR	Middle LEE	Last FORD	2d. DATE OF DEATH Month 10	2b. HOUR 11:30A	
3. SEX MALE	4. RACE NEGRO	5. DATE OF BIRTH 10/3/15		6. AGE (In years last birthday) 53	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE COUNTY, Md		
10 CITY OR TOWN OF DEATH FORT HOWARD	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VET. A.M. HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of work no. if ever, if retired) ELEVATOR OPERATOR		12b. KIND OF BUSINESS OR INDUSTRY STATE OF MARYL	
13a. USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE MARYLAND	13b. COUNTY —	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1348 N. Stricker Street		
14. FATHER'S NAME First LEWIS FORD	Middle 	Last 	15. MOTHER'S MAIDEN NAME First INDIA	Middle 	Last HAWKES	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES	16b. SOCIAL SECURITY NO. WW II	17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.	Address UNKNOWN			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) UREMIA 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOLAR NEPHROSCLEROSIS UNKNOWN						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) HYPERTENSIVE CARDIOVASCULAR DISEASE						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9/19/68 , 19_____, to 10/18/68 , 19_____, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10/18/68 , 19_____, and that <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (I) <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (did) <input checked="" type="checkbox"/> (did not) view the body after death.						
22b. SIGNATURE <i>Neilson Neilson, M.D.</i>	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED 10/18/68		
22d. PHYSICIAN'S NAME (Type) NEILSON NEILSON, M. D.	22e. ADDRESS VAH FORT HOWARD, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 10-23-68	23c. NAME OF CEMETERY OR CEMETORY Balto. Nat'l. Cem.	23d. LOCATION (City or Town) Baltimore, Maryland	(County) 	(State) 	
24. FUNERAL DIRECTOR V.R. Bailey Kelson Funeral Home	ADDRESS 1348 Calhoun St.	25a. REC'D BY REGISTRAR DATE OCT 22 1968	25b. REGISTRAR'S SIGNATURE <i>G. Kelson Judge</i>			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												14006	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1 DECEASED-NAME 13995		First ALVIN		Middle RAYMOND		Lost		2a DATE KNOWN OF ESTI- DEATH MATED		Month ✓ 19	Day	Year	2b HOUR M
3 SEX Male		4 RACE White		5 DATE OF BIRTH 1/3/19 1921		6 AGE (in years last birthday) 49 yrs		7f UNDER 1 YEAR MONTHS 49		7f UNDER 24 HRS DAYS 7		7g HRS 17	
7b BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W.DOWED <input type="checkbox"/> D.VORCED		9 COUNTY OF DEATH BALTIMORE		2c. DATE PRONOUNCED DEAD Month October		Day 19	Year 1968	2d HOUR 6:25 A.M.	
10 CITY OR TOWN OF DEATH Ellicott City		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 6 Oella Avenue		12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) Shipping Clerk		12b KIND OF BUSINESS OR IND. STRY Donut Corp							
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b COUNTY Baltimore		13c CITY OR TOWN Ellicott City		13d INSIDE CITY, M.T.S.P. YES		13e STREET AND NUMBER 6 Oella Avenue					
14 FATHER'S NAME Charles W. Funk		15 MOTHER'S MAIDEN NAME Gertrude Piffer											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16b SOCIAL SECURITY NO W.W. 2 219 03 4502		17 INFORMANT Garland Funk 3602 Lilac Ave. Balto. 21227, Md.		ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause +124 (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 411													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20 AUTOPSY?			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) Charles S. Springate, M.D.												ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE 10/23/68		23c. NAME OF CEMETERY OR CREMATORIAL Good Shepherd		23d. LOCATION (City or Town) Ellicott City		(County) Howard		(State) Md.			
24. FUNERAL DIRECTOR Higinbotham Slack		ADDRESS Ellicott City, Md.		25a. RECEIVED BY REGISTRAR DATE OCT 23 1968		25b. REGISTRAR'S SIGNATURE 							



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14007

13995

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper pages and 2 director, page 3 should be detached for use as the burial permit. Then please remove carbon paper pages and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

1. DECEASED-NAME (Type or print)		First SAMUEL	Middle GARBIS	2a. DATE OF DEATH Month OCTOBER	Day 7	Year 1968	2b. HOUR 11:45PM	
3. SEX MALE		4 RACE WHITE	S. DATE OF BIRTH SEPTEMBER 15, 1909	6. AGE (In years last birthday) 99		IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE		12b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED		
10 CITY OR TOWN OF DEATH GARRISON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) FOXLEIGH NURSING HOME		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) UPHOLSTERY				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMIT? YES	13e. STREET AND NUMBER 6805 GIST AVENUE			
14. FATHER'S NAME First ISRAEL		Middle GARBIS	15. MOTHER'S MAIDEN NAME First ANNA	Middle	Last	16. SOCIAL SECURITY NO 217-12-8372		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES		16b. INFORMANT MRS. ADELE GARBIS, 6805 GIST AVE. #21215		Address		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mo.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain tumor (glioblastoma) DUE TO, OR AS A CONSEQUENCE OF 191X Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from July 1968 , to Oct 7, 1968 , that (I) (we) last saw the deceased alive on Sept 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Irvin Sauber</i>		MD DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED Oct 14, 1968			
22d. PHYSICIAN'S NAME (Type) IRVIN SAUBER		22e. ADDRESS 6905 PARK HEIGHTS AVENUE						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 10-10-68	23c. NAME OF CEMETERY OR CREMATORIUM MOSES MONTIFIORE		23d. LOCATED ON (City or Town) (County) (State) BALTIMORE, MARYLAND			
24. FUNERAL DIRECTOR		ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Oct 14 1968			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 8. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14008

1 DECEASED NAME (Type or Print)	First	Middle	Last	2a DATE KNOWN OF ESTI- MATED	Month	Day	Year	2b HOUR	
KENNETT L. GARMAN				OCT 7 1968				M	
3 SEX	4. RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	7 IF UNDER 1 YEAR MONTHS	8 IF UNDER 24 HRS DAYS	9 HOURS	10 MIN.	2d HOUR	
M	W	3/22/19	49 YRS						
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH						
PA.	USA	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	BALTO.						
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
ESSEX	1624 EASTERN AVE			Md.			MARTIN CO		
13a USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER					
MD.	BALTO.	ESSEX	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	1629 EASTERN AVE					
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last		
LEROY GARMAN				MAEGLIE BEVENS					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b SOCIAL SECURITY NO (If yes give war or dates of service)	17 INFORMANT	ADDRESS						
YES	WW II	173-05-902	KATHRYN GARMAN ABOVE						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ocute Coronary Occlusion</u> DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Excessive Obesity</u>									
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Neal Patterson</u>	EXAMINER'S NAME (Type) <u>NEAL PATTERSON</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county) 10/7/68					
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORIAL ESTABLISHMENT	23d LOCATION (City or Town) GEULERSVILLE	(County)	(State)	22b. DATE SIGNED	10/7/68		
REMOVAL	10/9/68	300 MACE	J.G. CONNELLY, SCS-S						
24. FUNERAL DIRECTOR	ADDRESS	25a REC'D BY REGISTRAR	25b REGISTRAR'S SIGNATURE						
J.G. CONNELLY, SCS-S	300 MACE	OCT 9 1968	Charles Judge						



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14009

CERTIFICATE OF DEATH

13995

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH Oct Month 9 Day 1968		2b. HOUR 255 M	
3. SEX Female		4. RACE WHITE		5. DATE OF BIRTH 12/10/77		6. AGE (In years lost birthday) 90 yrs.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH Baltimore		Md.		
10. CITY OR TOWN OF DEATH Catoonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address). House in the Pines				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) House work		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Res dence before admission) STATE Maryland		13c. CITY OR TOWN Baltimore Arbutus		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5504 Carville Ave.				
14. FATHER'S NAME Bruffett Taylor		First	Middle	Last	15. MOTHER'S MAIDEN NAME Helen Lane		First	Middle	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No		16b. SOCIAL SECURITY NO 213-48-6492		17. INFORMANT Helen Kelly		Address 5504 Carville Ave.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Colon</i>										
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) HSCUD-										
19a. MEDICAL CERTIFICATION DATE		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE-BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>July 19, 1968</u> , to <u>Oct 9, 1968</u> , that (I) (we) last saw the deceased alive on <u>Oct 1, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE EARL PASS MR		DEGREE ATTENDING PHYS		22c. DATE SIGNED 10-9-68						
22d. PHYSICIAN'S NAME (Type) EARL PASS		22e. ADDRESS 4001 WILKENS Ave								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/12/68		23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cem		23d. LOCATION (City or Town) Baltimore Maryland		(County) (State)		
24. FUNERAL DIRECTOR Ambrase Inc 1328 Sulphur Sq. Rd.		ADDRESS		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14010

CERTIFICATE OF DEATH

1	13898	2a. DATE OF DEATH Month 10 Day 23 Year 68	2b. HOUR 5:50 AM				
1. DECEASED - NAME (Type or print) Bernard Horace GASS		3. SEX Male	4. RACE White	5. DATE OF BIRTH 8/23/29	6. AGE (In years lost birthday) 39 YRS	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS HOURS MIN
7. BIRTHPLACE (State or foreign country) Maryland		8. CITIZEN OF WHAT COUNTRY? U.S.A.		9. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore		
10. CITY OR TOWN OF DEATH Owings Mills		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rosewood State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Dependent		12b. KIND OF BUSINESS OR INDUSTRY none	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13c. CITY OR TOWN St. Mary		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Abell		
14. FATHER'S NAME First John		Middle Edward	Last GASS	15. MOTHER'S MAIDEN NAME First Lola	Middle Lee	Last HAYDEN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO ---		17. INFORMANT Rosewood Records, Owings Mills, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition and Dyscrasia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause 5'71.8 lost. (b) Post-sclerotic Cirrhosis of the Liver DUE TO, OR AS A CONSEQUENCE OF (c)							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 5810 Mongolism							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from 7/7 , 19 65 , to 10/23 , 19 68 , that <input type="checkbox"/> (we) last saw the deceased alive on 10/23 19 68 , and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> (we) (did) <input type="checkbox"/> (did not) view the body after death.							
22b. SIGNATURE <i>Harry G. Butler, M.D.</i>		DEGREE ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 10/23/68		
22d. PHYSICIAN'S NAME (Type) Harry G. Butler, M.D.		22e. ADDRESS Rosewood St. Hosp., Owings Mills, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/26/1968	23c. NAME OF CEMETERY OR CREMATORIAL Sacred Heart		23d. LOCATION (City or Town) Bushwood, St. Marys Md.	(County)	(State)
24. FUNERAL DIRECTOR <i>W. Clarke Mattingley, Leonardtown, Md.</i>		ADDRESS	25a. REC'D BY REGISTRAR DATE OCT 28 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled up by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers from pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14000

14011

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the attending physician, then please remove carbon papers. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be detached for use as the burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First ELENORA	Middle ELIZABETH	Last GEELHAAR	2a. DATE OF DEATH Month OCTOBER 19, 1968 Day Year 1968	2b. HOUR 2:40 P.M.	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH FEB. 4, 1903	6. AGE (in years last birthday) 65 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE 4			
10. CITY OR TOWN OF DEATH TOWSON 4,	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b. COUNTY BALTIMORE	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 9629 10th Avenue		
14. FATHER'S NAME First Albert Merson	Middle	Last	15. MOTHER'S MAIDEN NAME First Unknown	Middle	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) None	17. INFORMANT Family records	Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Pulmonary Embolism						
450X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
450X						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22o. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from OCT. 10, 1968 , to OCT. 19, 1968 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on OCT. 19, 1968 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Christina Feliciano, M.D.</i>	DEGREE ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED OCT. 19, 1968		
22d. PHYSICIAN'S NAME (Type) Christina Feliciano, M.D.	22e. ADDRESS 7620 YORK ROAD, TOWSON 4, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 10/22/68	23c. NAME OF CEMETERY OR CREMATORIUM Dulaney Valley Cem.	23d. LOCATION (City or Town) Balto Co. Md.	(County)	(State)	
24. FUNERAL DIRECTOR C.F. EVANS & SON 8802 Harford road	ADDRESS	25a. REC'D BY REGISTRAR DATE OCT 22 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



14012

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR AM
<i>Jeanette Gloss</i>						Oct	27	68	11:55 A.M.
3. SEX		4. RACE	5. DATE OF BIRTH			6 AGE (In years last birthday)		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
<i>F</i>		<i>W</i>	<i>FEB 10 - 93</i>			75 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH			
Maryland		U.S.A.				<i>Baltimore</i>			Md.
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
<i>Randallstown, md</i>			<i>Baldo Co. General Hosp.</i>			<i>Housewife</i>			
13a. USUAL RESIDENCE (Where deceased, if not in hospital: Residence before admission) STATE		13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER		
Maryland		Baldo Co.	Randallstown			NO	3806 Brown Hill Rd.		
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
<i>?</i>			<i>?</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown		16b. SOCIAL SECURITY NO			17 INFORMANT		Address		
		<i>219-30-4625</i>			<i>Mr. Jerome J. Gloss-11900 Reisterstown Rd.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic cardiovascular Disease</i>									
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4109</i>									
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <i>10-20</i> , 19 <i>68</i> , to <i>10-27</i> , 19 <i>68</i> , that <input type="checkbox"/> (I) <input checked="" type="checkbox"/> (we) last saw the deceased alive on <i>10-27</i> , 19 <i>68</i> , and that in <input type="checkbox"/> (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> (I) <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (did not) view the body after death.									
22b. SIGNATURE <i>G. Dearborn, MD</i>		22c. DEGREE		ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22d. DATE SIGNED <i>10-27-67</i>		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
23a. BURIAL, CREMATION REMAINS (Type)		23b. DATE <i>Oct. 29, 68</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Evergreen Memorial Gardens</i>		23d. LOCATION (City or Town) <i>Finksburg Carroll Md.</i>		(County)	(State)
24. FUNERAL DIRECTOR <i>Loring Byers</i>		ADDRESS <i>8728 Liberty Rd. Randallstown.</i>		25a. REC'D. BY REGISTRAR <i>OCT 29 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14003

14013

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers bag and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) Fannie Lee Goodloe				2a. DATE OF DEATH Month October Day 3 , Year 1968			2b. HOUR 9:00 p.m.						
3. SEX female		4. RACE white		5. DATE OF BIRTH Sept. 24, 1877		6. AGE (In years last birthday) 98 91 yrs		IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN. 0					
7a. BIRTHPLACE (State or foreign country) Penn.		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore							
10. CITY OR TOWN OF DEATH Catonsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife			12b. KIND OF BUSINESS OR INDUSTRY Md.				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Bowie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER R.F.D. #1					
14. FATHER'S NAME First Unknown			15. MOTHER'S MAIDEN NAME First Unknown										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 213-50-5974		17. INFORMANT J.J. Records: SPRING GROVE STATE HOSPITAL					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause Arteriosclerotic cardiovascular disease (b) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 4-1-1													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 P.M. 19 Month May Day 3 Year 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at office <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. Spring Grove State Hospital		City or Town Baltimore		County Maryland		State Md.			
22a. I certify that (I) (this hospital) attended the deceased from May 3, 1968 , to Oct. 3, 1968 , that (I) (we) last saw the deceased alive on Oct. 3, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did not) view the body after death.													
22b. SIGNATURE D. L. Pirovolidis		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10-4-68			
22d. PHYSICIAN'S NAME (Type) Diomidis L. Pirovolidis, M.D.		22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/8/1968		23c. NAME OF CEMETERY OR CREMATORIAL Lincoln		23d. LOCATION (City or Town) Suitland, Maryland		(County) Maryland		(State)			
24. FUNERAL DIRECTOR Ernest Jarvis Co. Inc.		ADDRESS 1132 U St. N.W.		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge		DATE OCT 7 1968					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

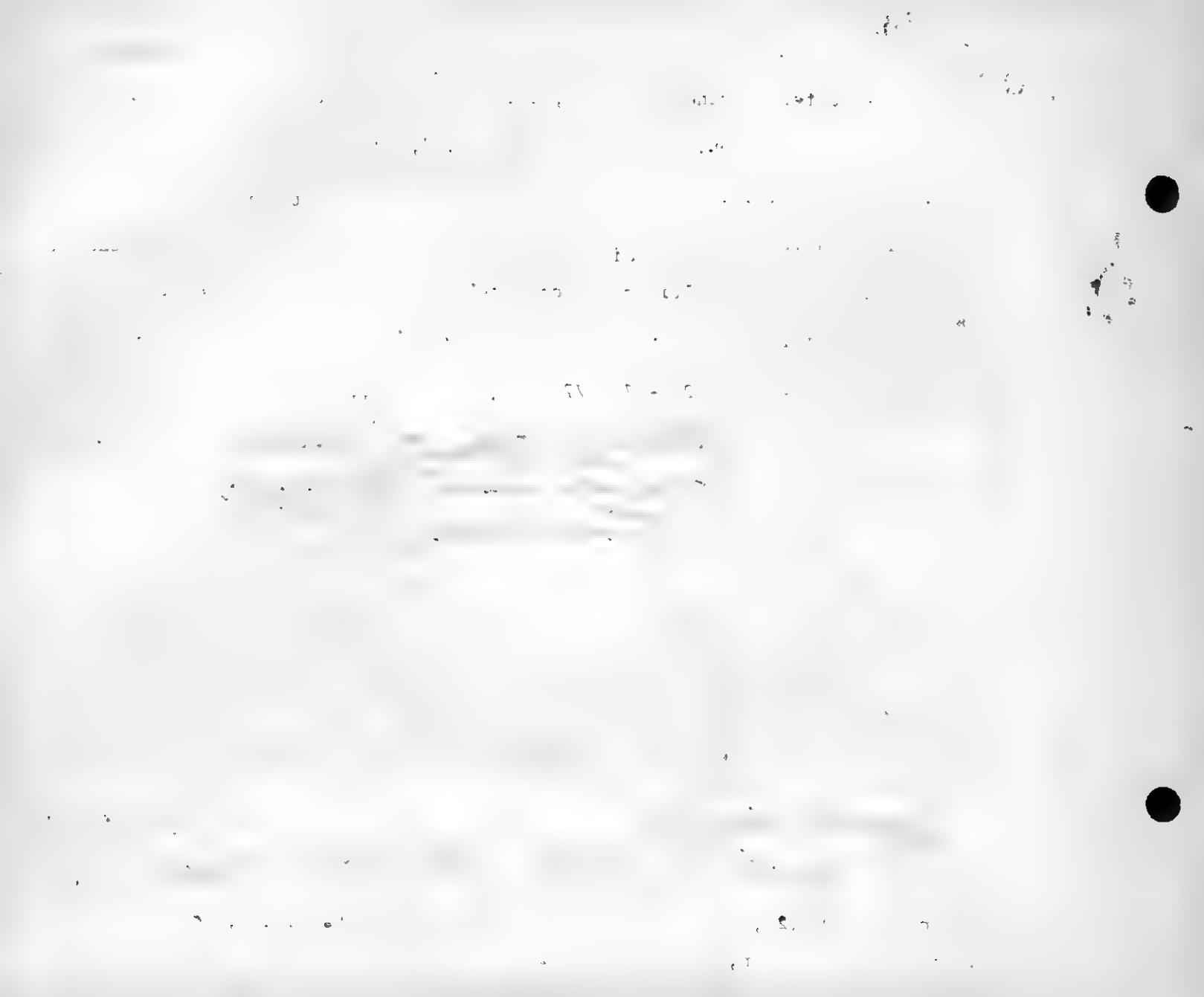
CERTIFICATE OF DEATH

14014

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Walter	Middle Franklin	Last Gover, Sr.	2a DATE OF DEATH Month Oct. 18 Day 1968	2b. HOUR		
3 SEX Male	4 RACE Cay.	5. DATE OF BIRTH Sept. 7, 1913		6 AGE (In years last birthday) 35 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (State or foreign country) Md.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9 COUNTY OF DEATH Baltimore				
10 CITY OR TOWN OF DEATH Cockeysville (Texas)	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Railroad Ave		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Labor	12b. KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.	13b. COUNTY Baltimore	13c CITY OR TOWN Cockeysville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER Railroad Ave.			
14. FATHER'S NAME Walter	Middle Gover	15. MOTHER'S MAIDEN NAME First Virgie	Middle Last Ford				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes	16b. SOCIAL SECURITY NO. Mar 41-Aug 44	17 INFORMANT Margaret Gover, Same as # 13	Address				
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Bacitracin of brain</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr	
(b) <i>metastasis to lung</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Sachexia</i>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (if either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>10-18-68</i> , to <i>10-18-68</i> , that (I) last saw the deceased alive on <i>10-18-68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>James Q. Saffell</i>		DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED <i>10-19-68</i>		
22d. PHYSICIAN'S NAME (Type) <i>James Q. Saffell</i>		22e ADDRESS <i>Berister's town, MD</i>					
23a. BURIAL, CREMATON, REMOVAL (Specify) <i>Burial</i>		23b. DATE Oct. 21, 1968	23c. NAME OF CEMETERY OR CREMATORIUM Poplar Grove Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Rd. 21204				ADDRESS	25a. REC'D BY REGISTRAR DATE OCT 21 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE
HEALTH DEPT.

Any delay in sending this certificate will result in a fine of \$100. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS 200.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death in person. Item 8. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files.

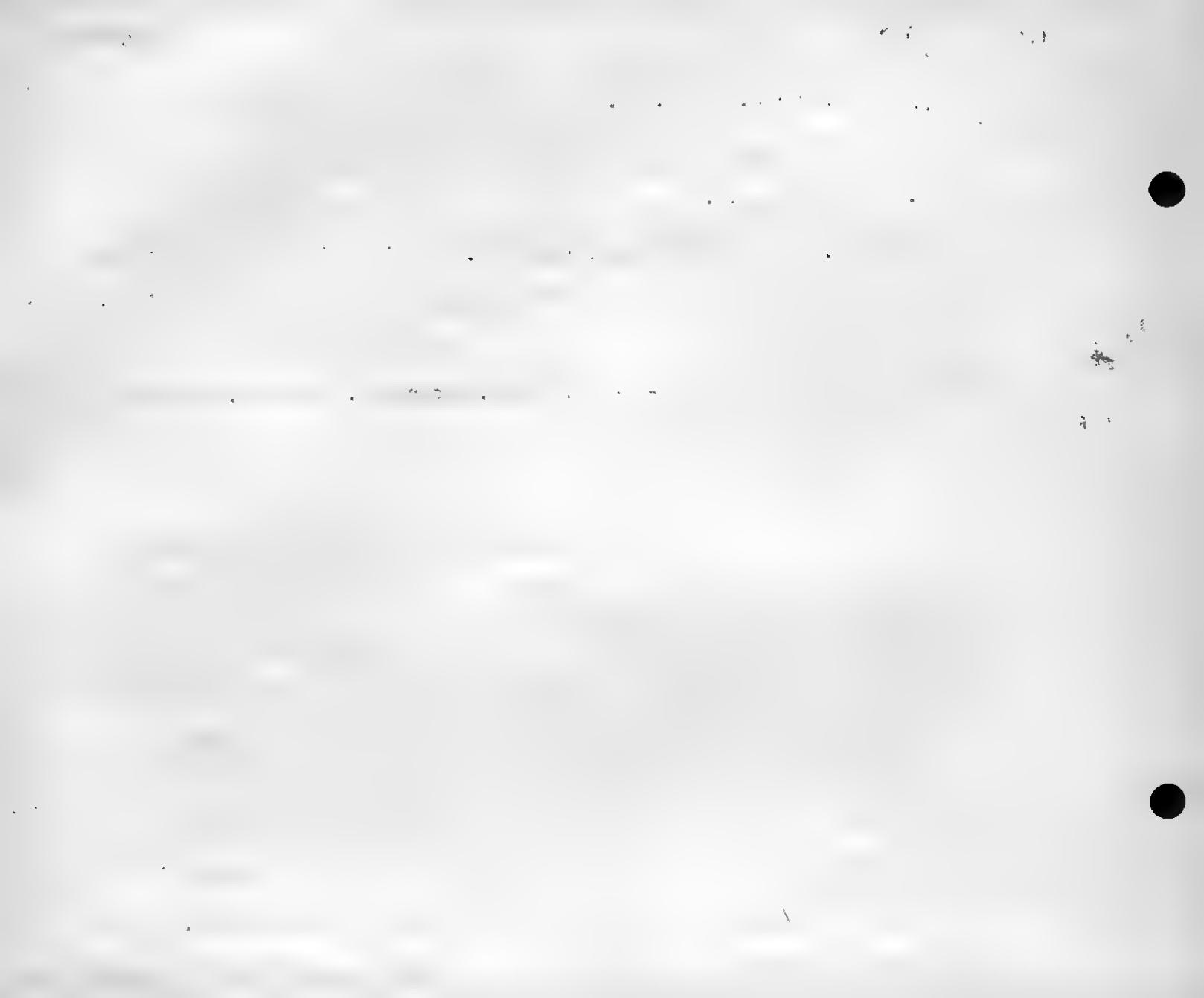
5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14015

1 DECEASED-NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN Month Day Year	2b HOUR 30 AM
George J. Grace, Sr.						DEATH MATED <input type="checkbox"/> 10/27 1968	
3 SEX Male	4 RACE White	5 DATE OF BIRTH 2/22/14	6 AGE (In years last birthday) 54 yrs	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS M.M.	2c DATE PRONOUNCED DEAD Month 10 Day 24 Year 1968/12/M	2d HOUR 00
7a BIRTHPLACE (State or foreign country) Md.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED WIDOWED DIVORCED	9 COUNTY OF DEATH Baltimore				
10 CITY OR TOWN OF DEATH Lansdowne, Md.		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2222 Hammonds Ferry Rd.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Painter		12b KIND OF BUSINESS OR INDUSTRY Painting
13a USUAL RESIDENCE (Where deceased lived, if institut. on. Residence before admission) STATE Md.	13b COUNTY Baltimore	13c CITY OR TOWN Baltimore	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER 2222 Hammonds Ferry Road			
14 FATHER'S NAME William Grace		15 MOTHER'S MAIDEN NAME Katherine Eichelman			ADDRESS Ferry Rd		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16b SOCIAL SECURITY NO (If yes give war or dates of service) 215-16-2667	17 INFORMANT Mrs. George J. Grace, Sr. 2222 Hammonds Ferry Rd.	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last 5719 (b) Cirrhosis Liver DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Accidents Seizure Episodes unknown Etio.							
19a DATE OF OPERATION 19c CONDITION FOR WHICH OPERATION WAS PERFORMED?		19b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 9			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21b PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	21f LOCATION Street or R.F.D. No City or Town County State				
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) James N. Frederick	MD			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) 1311 Francis Ave Balto, Md.	22b DATE SIGNED 10/24/68		
23a BURIAL, CREMATION REMOVAL (Specify) Burial	23b DATE 10/28/68	23c NAME OF CEMETERY OR CREMATORIAL New Cathedral cemetery	23d LOCATION (City or Town) Baltimore, Md.	(County)	(State)		
24 FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave., 21229	ADDRESS			25a. REC'D BY REGISTRAR DATE OCT 28 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14005

14016

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)	First George	Middle Wilson	Last Groom	2a. DATE OF DEATH Month 10	Day 3	Year 68	2b. HOUR P 11:45 M
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH 7/4/97			6. AGE (In years last birthday) 71	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Baltimore			12b. KIND OF BUSINESS OR INDUSTRY LODGE	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Med. Center			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) SECRETARY-RET.			12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if admission) STATE MARYLAND	13b. COUNTY BALTIMORE	13c. CITY OR TOWN ROGERS FORGE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 249 ROGERS FORGE RD.			
14. FATHER'S NAME FRED A. GROOM	First	Middle	Last	15. MOTHER'S MAIDEN NAME MARGARET WILSON	Middle	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes NO	16b. SOCIAL SECURITY NO WWI	17. INFORMANT Family Records				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (a) Acute myocardial infarction 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive arteriosclerotic cardiovascular DUE TO, OR AS A CONSEQUENCE OF (c) disease with coronary atherosclerosis							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from 8/13, 19 68, to 10/3, 19 68, that (I) (we) last saw the deceased alive on 10/3 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Charles C. Brown, M.D.		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 10/4/68		
22d. PHYSICIAN'S NAME (Type) Charles C. Brown, M.D.		22e. ADDRESS 6701 N. Charles Street					
23a. BURIAL, CREMATON, KNOWN OR SUSPECTED	23b. DATE OCT. 7. 1968	23c. NAME OF CEMETERY OR CREMATORIUM BALTIMORE NATL. CEM.			23d. LOCAT ON (City or Town) BALTIMORE, MD.	(County)	(State)
24. FUNERAL DIRECTOR John Burns Sons Sonson	ADDRESS	25a. REC'D BY REGISTRAR DAT OCT 7 1968			25b. REGISTRAR'S SIGNATURE Charles Juge		



Item 6 FilmG407 12/3/68 kk MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14006

CERTIFICATE OF DEATH

14017

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please retain carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours of death.

1. DECEASED NAME (Type or print)	First August	Middle Gross	Last Gross	2a DATE OF DEATH Month October	Day 27	Year 1968	2b HOUR 12:30 P.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH 1882		6. AGE (In years last birthday) 85	IF UNDER 1 YEAR MONTHS 0		IF UNDER 24 HRS. DAYS 86
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. COUNTY OF DEATH Baltimore			
10. CITY OR TOWN OF DEATH Owings Mills	11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Rosewood		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) dependent		12b. KIND OF BUSINESS OR INDUSTRY none		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1125 Franklin Street			
14. FATHER'S NAME First August	Middle Gross	Last Gross	15. MOTHER'S MAIDEN NAME Amelia	Middle	Last Poehnert		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO 215-50-6890	17. INFORMANT Patient's chart	Address Rosewood				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Sore Throat, Cough, Cyanosis, Right, Left Sided</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Congestive Heart Failure</i> . DUE TO, OR AS A CONSEQUENCE OF (c)							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs. YES							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State	
22a. I certify that (s) (this hospital) attended the deceased from 8/31/68, to 10/27, 1968, that (s) (we) last saw the deceased alive on 10/27, 1968, and that in (s) (our) opinion death occurred on the date and hour and from the causes stated above, (s) (we) (do not) view the body after death.							
22b. SIGNATURE <i>Richard A. Jones, M.D.</i>		DEGREE ATTENDING PHYS	<input type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 10/28/68		
22d. PHYSICIAN'S NAME (Type) Richard A. Jones, M.D.		22e. ADDRESS Rosewood State Hospital, Owings Mills, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/30/1968	23c. NAME OF CEMETERY OR CREMATORIUM Lorraine Park Cemetery	23d. LOCATION (City or Town) Baltimore, Md.	(County) (State)		
24. FUNERAL DIRECTOR Sandy Funeral Home York Rd		ADDRESS 5209	25a. REG'D BY REGISTRAR DATE OCT 30 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14018

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First <i>C.</i>	Middle <i>Franklin</i>	Last <i>Grubb</i>	2a. DATE OF DEATH Month <i>Oct.</i> Day <i>18</i> Year <i>68</i>	2b. HOUR <i>1:30 P.M.</i>					
3. SEX <i>Male</i>		4. RACE <i>Cauc.</i>	5. DATE OF BIRTH <i>Feb. 6, 1891</i>		6. AGE (in years last birthday) <i>77</i>	7. UNDERTAKER MONTHS <i>YRS.</i>	8. UNDER 24 HRS MONTHS <i>0</i>	9. IF UNDER 24 HRS DAYS <i>0</i>	10. IF UNDER 24 HRS HOURS <i>0</i>	11. IF UNDER 24 HRS MIN <i>0</i>	
7a. BIRTHPLACE (State or foreign country) <i>Va.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Balto.</i>					
10. CITY OR TOWN OF DEATH <i>White Hall</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Graystone Rd.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Farmer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i>		13c. CITY OR TOWN <i>Balto. White Hall</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>Graystone Rd.</i>					
14. FATHER'S NAME <i>Albert</i>		Middle <i>Grubb</i>	Last	15. MOTHER'S MAIDEN NAME First <i>Rebecca</i>		Middle <i>Rakes</i>	Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO (If yes give war or dates of service) <i>214-34-2858</i>		17. INFORMANT <i>Mrs. Lona J. Grubb, White Hall, Md.</i>		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>1621</i>		<i>A.S.C.V. disease</i>									
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF <i>Carcinoma of the lung</i>									
(b)											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <i>1950</i> , to <i>1968</i> , that (I) (we) last saw the deceased alive on <i>10/17 1968</i> , and that in (my) (<input type="checkbox"/>) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>P.M. France M.D.</i>		22c. DEGREE <input type="checkbox"/> MED. PHYS. <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. DATE SIGNED <i>10/19/68</i>							
22d. PHYSICIAN'S NAME (Type) <i>P.M. FRANCE</i>		22e. ADDRESS <i>PARKTON MD.</i>									
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE <i>10/20/68</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Wiseburg Cemetery</i>		23d. LOCATION (City or Town) <i>White Hall, Balto, Md.</i>		(County)		(State)	
24. FUNERAL DIRECTOR <i>James J. Hartenstein, New Freedom, Pa.</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE					
VR 1541 30M REV 1-68				DATE <i>OCT 22 1968</i>							



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14019

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, attach to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. If any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. DECEASED NAME (Type or print)		2. First <i>Lillian</i>	Middle Last <i>Hampshire</i>	3. DATE OF DEATH Month 10 Day 17 Year 1968	2b. HOUR AM
3. SEX <i>F</i>	4 RACE <i>W</i>	5. DATE OF BIRTH <i>11-1st-1885</i>	6. AGE (In years last birthday) <i>83</i>	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Baltimore</i>		
10. CITY OR TOWN OF DEATH <i>Baltimore</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Baltimore General Hospital</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>		
13a. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) STATE <i>Baltimore, Md.</i>	13c. CITY OR TOWN <i>Baltimore</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>10-720 Federal Rd.</i>		
14. FATHER'S NAME First <i>John</i>	Middle <i>Wiedefeld</i>	Last <i>Gaines</i>	15. MOTHER'S MAIDEN NAME First <i>Gaines</i>	Middle <i>Jessie</i>	Last <i>Gaines</i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16b. SOCIAL SECURITY NO. <i>(If yes give war or dates of service)</i>	17. INFORMANT <i>John D. Hampshire</i>	Address <i>611 Coventry Rd. #21204</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>451.9</i> <i>None</i> (b) <i>Cerebral arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> <i>7 years</i>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>None</i>					
19a. DATE OF OPERATION <i>None</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>None</i>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <i>None</i>	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>None</i>			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory) (OFFICE BUILDING, ETC.) <i>None</i>	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct. 16, 1968</i> , to <i>Oct. 17, 1968</i> , that (I) (we) last saw the deceased alive on <i>Oct. 16, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (they) (did not) view the body after death.					
22b. SIGNATURE <i>Myron Gaines Jr.</i>	DEGREE ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>Oct. 17, 1968</i>		
22d. PHYSICIAN'S NAME (Type) <i>Br. L. Myrton Gaines, Jr.</i>	22e. ADDRESS <i>7800 York Road Baltimore, Md. 21204</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>10/19/68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Druid Ridge</i>	23d. LOCATION (City or Town) <i>Baltimore County, Md.</i>	(County)	(State)
24. FUNERAL DIRECTOR <i>Mitchell-Wiedefeld Home 6500 York Rd. Baltimore, Md. 21212</i>	ADDRESS	25a. REC'D BY REG STRR <i>OCT 22 1968</i>	25b. REG STRR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1400\$

14020

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers page 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR 9:15 PM
<i>Margaret M. Hardt</i>					Oct. 31 1968	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
Female	white	Dec. 19, 1884		83 yrs		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
U.S.A.	U.S.A.			<i>Baltimore Co.</i>		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
<i>Catonsville</i>	<i>Summit Nursing Home</i>				<i>1217 Camberwell Rd.</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER		
<i>Maryland</i>	<i>Baltimore</i>	<i>Baltimore</i>		<i>1217 Camberwell Rd.</i>		
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle
<i>Thomas J. Rich</i>				<i>Mary Katherine Martney</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address			
No	215-03-5502	J Richard Hardt Balt Md 21228				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))						
PART I. DEATH WAS CAUSED BY						
IMMEDIATE CAUSE (a) <i>De-Terio Sclerotic Cardiosclerotic Disease</i>						
DUE TO, OR AS A CONSEQUENCE OF <i>(Pacemaker)</i>						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost						
(b) <i>Renal Insufficiency - Chronic Glomerulonephritis, 28 Anemia.</i>						
DUE TO, OR AS A CONSEQUENCE OF <i>Nephritis, 28 Anemia.</i>						
(c) <i>Fracture of Right Hip, Urinary Tract Infection.</i>						
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify med cal examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 7-28-1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
				<i>Fell at home</i>		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <i>Home</i>		21f. LOCATION Street or R.F.D. No <i>4511 Manor Deane Rd</i>	City or Town <i>Oath. City, Md.</i>	County State
22a. I certify that (I) (this hospital) attended the deceased from <i>10/21/68</i> to <i>10/31/68</i> , that (I) (we) last saw the deceased alive on <i>10/30/68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>E. Kasai T. S. M.D.</i>		DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED <i>10/31/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>E. Kasai T. S. M.D.</i>		22e. ADDRESS <i>1801 Frederick Rd Balt. Md 21228</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>11/4/68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Loudon Park</i>	23d. LOCATION (City or Town) <i>Baltimore, Md</i>	(County)	(State)
24. FUNERAL DIRECTOR <i>John C. Cullum Funeral Service</i>		ADDRESS <i>6212 Baltimore Street</i>	25a. REC'D. BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
			DATE <i>NOV 13 1968</i>			

Y

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14021

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be presented within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 may be retained by the hospital or attending physician. This certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First MARGARET W HARDY	Middle	Last	2a. DATE OF DEATH Month OCT 10 1968	Day	Year	2b. HOUR M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH 1883 NOV. 1 1968		6. AGE (In years last birthday) 85 yrs		IF UNDER 1 YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore			
10. CITY OR TOWN OF DEATH BALTIMORE MD	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CATON RIDGE N. Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Baltimore Parkville	13c. CITY OR TOWN Parkville	13d. INSIDE CITY LIMIT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 2510 Burridge Rd			
14. FATHER'S NAME First JOHN	Middle	Last	15. MOTHER'S MAIDEN NAME First MARIE Minna Solvech	Middle	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)	16b. SOCIAL SECURITY NO		17. INFORMANT William J. Hardy Jr.	Address			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarct DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last ASCVD (b) Generalized Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Years						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Instant	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Years							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 Month 10 Day 10 Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from 6-13- , 19 68 , to 10-10-1968 , that (I) (we) last saw the deceased alive on 10-10-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Cesar Valle Caervo M.D.				DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 10-10-68
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 8629 Liberty Rd.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/14/68	23c. NAME OF CEMETERY OR CREMATORIAL Parkwood	23d. LOCATION (City or Town) Baltimore Maryland		(County) Maryland	(State)
24. FUNERAL DIRECTOR ADDRESS				25a. REG'D. BY REGISTRAR DATE OCT 11 1968	25b. REGISTRAR'S SIGNATURE Charles J. Ruck		
VR 410-14 30M REV. 1/68							



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5, may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with Health prior to burial, cremation or removal and in any event within 72 hours after death.

Item 13 Film #106 MARYLAND STATE DEPARTMENT OF HEALTH
10/29/68 kk DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
1001? MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14022

1. DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF ESTI- DEATH MATED		Month	Day	Year	2b. HOUR
GLEN STANLEY						HARRIS		<input checked="" type="checkbox"/>		10-20		1968	N
3 SEX	4. RACE	5. DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD		2d HOUR			
Male	Negro	9-23-51		17 YRS				Month Day Year		8:30 A.M.			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		BALTIMORE		M			
Maryland													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR give street address)		INSTITUTION (If not in hospital)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
TOWSON		Expressway Ruxton Road Overpass											
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER							
Md.		Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>		1615 E. 31st. Street							
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last				
Stanley Harris					Sadie MC Knight								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
(If yes, give year or dates of service)				Sadie Harris 1615 E. 31st St.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))													
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) Multiple severe injuries													
815.1 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (o). stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)													
818.4		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?							
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a EXTERNA CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year HOUR A.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)									
CAUSE OF DEATH		7:40 AM 10-20 1968		Passenger in auto-fixed object collision									
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State			
		Expressway		Ruxton Road Overpass		Baltimore		Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
Charles S. Springate, M.D. Signature													
ACTUAL SIGNATURE										CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)										ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED	
										DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		October 20, 1968	
23a. BURIAL (CREMATION, REMOVAL) (Specify)										ADDRESS		ADDRESS (Street, city town, or county)	
Burial 10-24-68 Baltimore National Cemetery, Md.													
24. FUNERAL DIRECTOR										ADDRESS		25a. DATE BY REGISTRATION STATE	
Wm. G. Springer, Jr., Phillips 1727 N Monroe												25b. EXTRASIGNATURE	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14023

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that Page 4 may be retyped by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in [by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. ~~Page 1~~ and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14024

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First WILLIAM	Middle MC CLELAN	Last HARTMAN	2a. DATE OF DEATH Month 10	Day 31	Year 68	2b. HOUR 2:10 PM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 8/21/15			6. AGE (In years last birthday) 53	IF UNDER 1 YEAR MONTHS 5	IF UNDER 24 HRS. DAYS 0
7a. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE COUNTY		
10. CITY OR TOWN OF DEATH FORT HOWARD	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VET. ADM. HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) MEAT PACKER			12b. KIND OF BUSINESS OR IND. STRY MEAT PACKING		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES	13e. STREET AND NUMBER 3243 ELLIOTT STREET			
14. FATHER'S NAME First BERNARD	Middle HARTMAN	Last	15. MOTHER'S MAIDEN NAME First MARGARET	Middle	Last HOGGE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) WW II 217 09 2967	17. INFORMANT Clin. Rec. VAH, Fort Howard, Maryland	Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA RIGHT LUNG						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 MONTHS	
16d/1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. CHRONIC MALNUTRITION							
16e. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CHRONIC MALNUTRITION							
MEDICAL CERTIFICATION	19a. DATE OF OPERATION 9/25/68	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED SCALENE LYMPH NODE BIOPSY TO LOOK FOR METASTATIC CANCER	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
	21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from Oct. 4, 1968, to Oct. 31, 1968, that <input type="checkbox"/> (we) lost saw the deceased alive on Oct. 31, 1968, and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input type="checkbox"/> (we) did <input type="checkbox"/> view the body after death.							
22b. SIGNATURE John C. Dummer, Jr. M.D.				DEGREE ATTENDING PHYS	<input type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 10/31/68
22d. PHYSICIAN'S NAME (Type) JOHN C. DUMLER, JR. M.D.	22e. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11-4-68.	23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National Cemetery	23d. LOCATION (City or Town) Baltimore, Maryland	(County)	(State)		
24. FUNERAL DIRECTOR Charles S. Zeiler	ADDRESS Hudson & Conkling Sts. Baltimore, Md.	25a. REC'D BY REGISTRAR NOV 6 1968	25b. REGISTRAR'S SIGNATURE Charles Judge				
VR A15 (4) 30M REV 1/68							



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14025

CERTIFICATE OF DEATH

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1		14016													
Itemized		File # 06 11/22/68 Jm													
1 PLACE OF DEATH		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)													
a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		e. IS RESIDENCE ON A FARM?							
BALTIMORE		TOWSON		APPROX 2 1/2 MO		BALTIMORE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
MARYLAND															
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		e. IS RESIDENCE ON A FARM?									
TOWSON		APPROX 2 1/2 MO		BALTIMORE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. DATE OF DEATH		Month		Day		Year					
STELLA MARIS Hospice		BENJAMIN AVE 4227 Frederick		Oct. 10 1968		Month		Day		Year					
3 NAME OF DECEASED (Type or print)		First Middle		4. DATE OF DEATH		Month		Day		Year					
FLORENCE		E. HASELHERST		Oct. 10 1968		Month		Day		Year					
5 SEX		6. COLOR OR RACE		7. MARRIED		8. DATE OF BIRTH		9. AGE (In years lost birthday)		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS			
F		W		NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		1876 3-17-1977		92 yrs		Months		Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country)		12. CITIZEN OF WHAT COUNTRY?									
NONE		NONE		BALTIMORE, MD		U.S.A.									
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. ADDRESS											
Joseph Kaiser		Hooker		STELLA MARIS Hospice Inc., Towson, Md.											
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT		19. INTERVAL BETWEEN ONSET AND DEATH									
No		219-48-8674		STELLA MARIS Hospice Inc., Towson, Md.		3 wks									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY.		19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
IMMEDIATE CAUSE (a) 4129 - Multiple CVA's - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		20a. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)											
(b) Generalized arteriosclerosis Due to		20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
(c) ASCVD -															
21. I certify that (I) (this hospital) attended the deceased from JULY 26, 1968, to Oct. 10, 1968, that (I) (we) last saw the deceased alive on Oct. 9, 1968, and that death occurred at 5:15A.M. from causes and on the date stated above.		22a. SIGNATURE E. Lee Robbins		22b. DATE SIGNED 10/10/68											
22c. PHYSICIAN'S NAME (Type)		E. Lee Robbins, M.D.		22d. ADDRESS Courtyard Apts. Towson, Md. Balto. Co.											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City or Town) (County) (State)									
BURIAL		OCT. 12, 1968		NEW CATHEDRAL		BALTIMORE									
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
WALTERS FUN'L HOME PRATT + STRICKER STS				DATE OCT 14 1968		Charles J. ...									



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14026

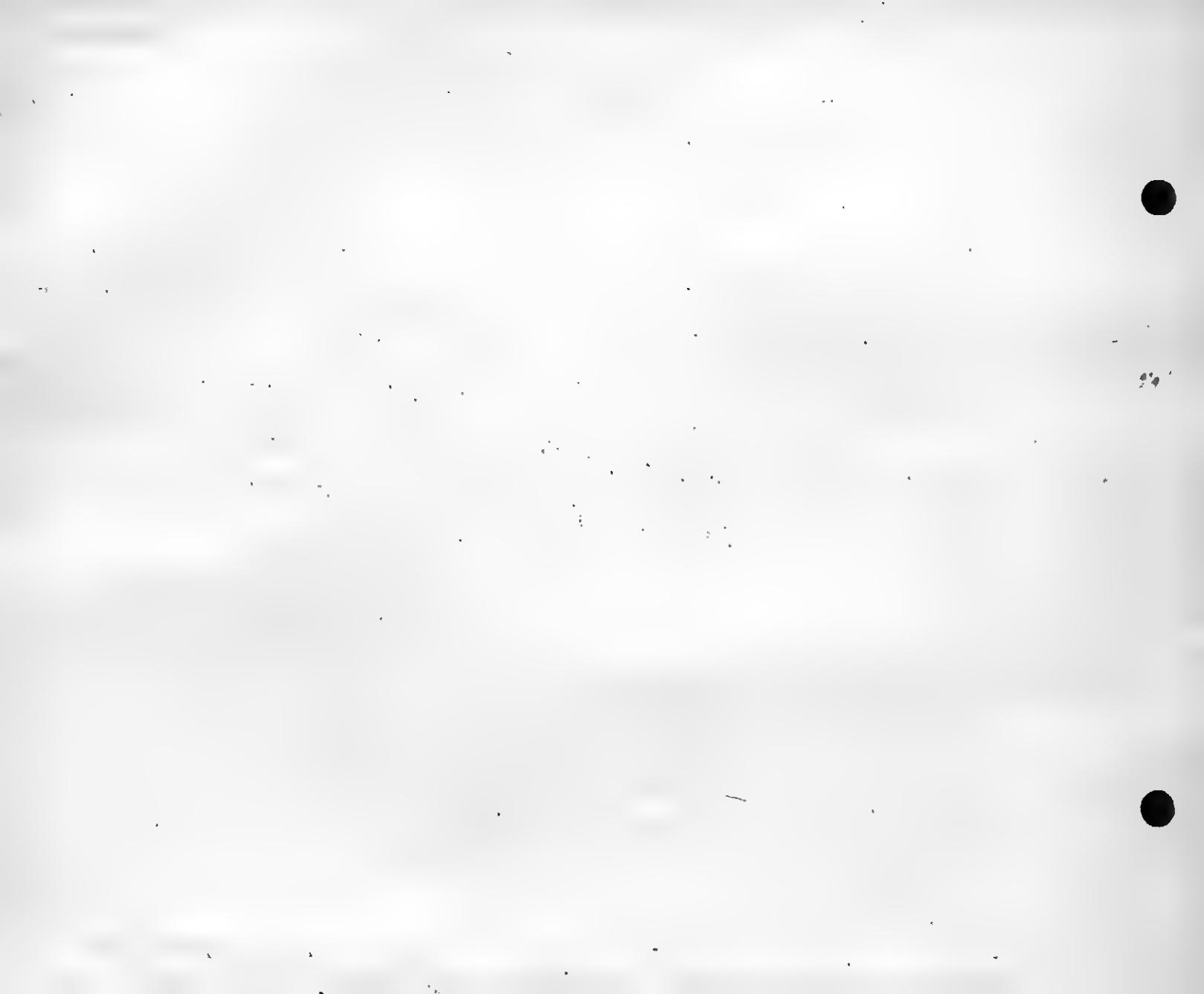
14015

1. DECEASED NAME (Type or print)	First Ella	Middle D.	Last Hauck	2a. DATE OF DEATH Month 10	Day 30	Year 1968	2b. HOUR 7:30 AM	
3. SEX F	4. RACE W	5. DATE OF BIRTH 7-16-1884		6. AGE (In years just birthday) 84		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) East Bend, N.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	B. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore				
8. WIDOWED <input checked="" type="checkbox"/>		DIVORCED <input type="checkbox"/>						
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Baltimore Valley Nursing		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Home Registered Nurse		12b. KIND OF BUSINESS OR INDUSTRY Nursing		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 5100 N. Charles Street		
14. FATHER'S NAME First John		Middle Willis	Last Davis	15. MOTHER'S MAIDEN NAME Henrietta		Last Lynch		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes		16b. SOCIAL SECURITY NO. 118-18-6914		17. INFORMANT Mrs. Alfred M. Durand		Address RD4 Wyalusing, Pa.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute heart failure. Acute</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) <i>Binal Sust. dolor. Arterosclerotic Monoth.</i> stating the underlying cause (b) <i>Degenerative CV. Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c)								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 422:								
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No.		City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct. 19, 52</i> to <i>30 Oct. 19, 68</i> , that (I) (we) last saw the deceased alive on <i>30 Oct. 19, 68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Joseph E. Muse Jr. MD</i>		ATTENDING PHYS.		MED. DIRECTOR		STAFF PHYS.	22c. DATE SIGNED 10/31/68	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS Dr. Joseph E. Muse, Jr.		22f. ADDRESS 2725 N. Charles Street				
23a. FUNERAL CREMATION, REMOVAL (Specify) Burial		23b. DATE 11-1-1968		23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National		23d. LOCATION (City or Town) Baltimore, (County) Md. (State)		
24. FUNERAL DIRECTOR Henry W. Jenkins & Sons Co.		ADDRESS 4905 York Road Balt., Md.		25a. REC'D. BY REGISTRAR NOV 1 1968		25b. REGISTRAR'S SIGNATURE <i>James J. George</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Page 4 may be retained by the hospital or attending physician.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

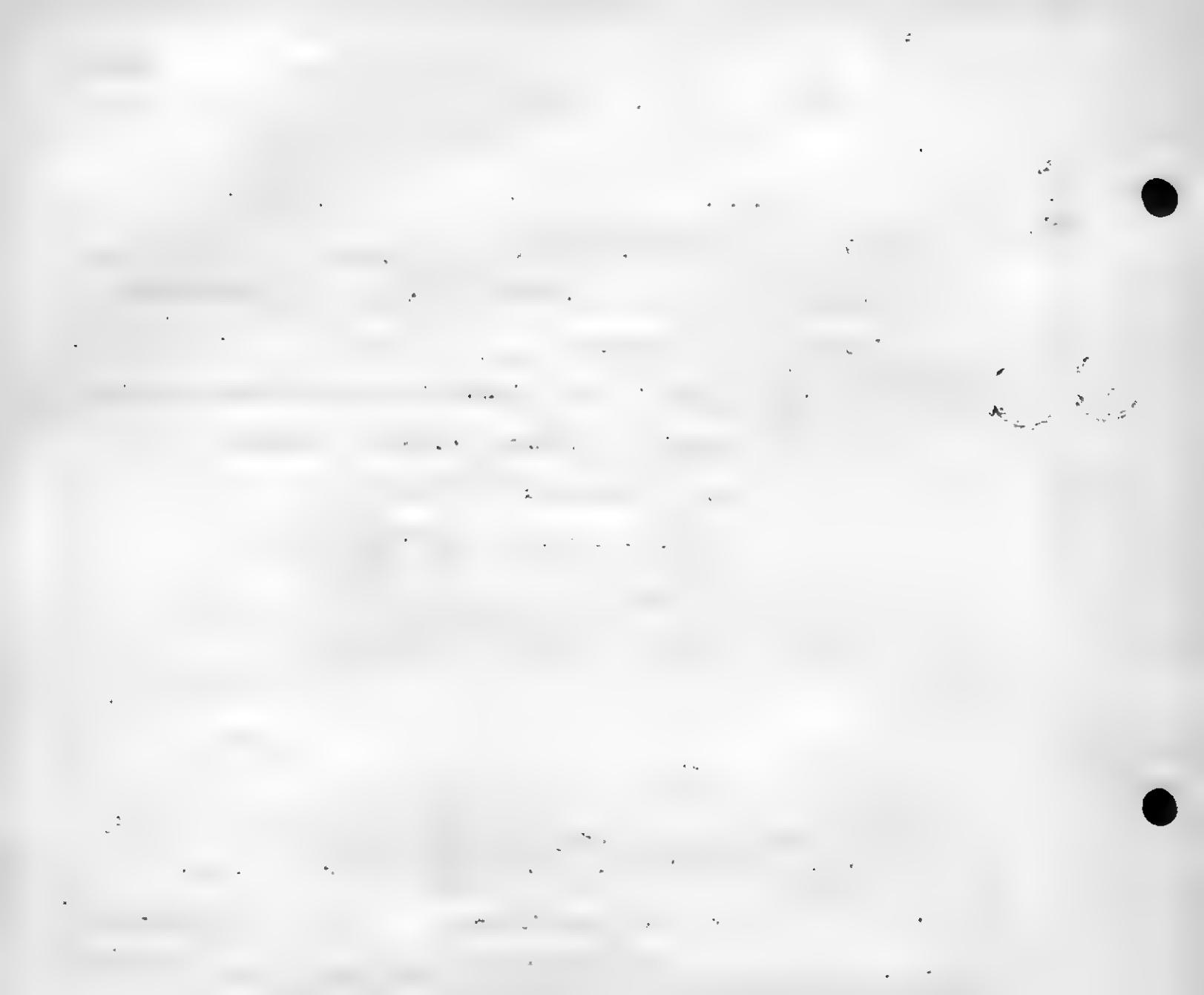
CERTIFICATE OF DEATH

14027

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 DECEASED NAME (Type or print)		First SAMUEL	Middle J.	Last HAWKINS	2a DATE OF DEATH Month 10	Day 9	Year 68	2b. HOUR 1:40AM	
3. SEX MALE		4 RACE NGERO	5. DATE OF BIRTH 4/16/89			6. AGE (In years last birthday) 79	F UNDER 1 YEAR MONTHS 0	F UNDER 24 HRS. DAYS 0	MIN 0
7a BIRTHPLACE (State or foreign) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE		
10 CITY OR TOWN OF DEATH FORT HOWARD		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital Give street address) VET. A.M. HOSPITAL			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CHAUFFEUR			12b. KIND OF BUSINESS OR INDUSTRY HOTEL	
13a. US/JAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND		13b. COUNTY —	13c CITY OR TOWN BALTIMORE			13d. INSIDE CITY LIMITS? YES	13e. STREET AND NUMBER 1312 Eutaw Place.		
14 FATHER'S NAME First George		Middle Hawkins	15 MOTHER'S MAIDEN NAME First Mary			Middle Jane	Last Carter		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES		16b SOCIAL SECURITY NO WW I 217 03 97 08			17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.			Address	
									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))</p> <p>PART 1. DEATH WAS CAUSED BY</p> <p>IMMEDIATE CAUSE (a) PNEUMONIA, BILATERAL UNDETERMINED ORGANISM</p> <p>4/29 DUE TO, OR AS A CONSEQUENCE OF</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause stating the underlying cause</p> <p>(b) ARTERIOSCLEROTIC HEART DISEASE</p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c) CARCINOMA COLON WITH METASTASES</p>									
<p>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p> <p>4/20</p>									
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	NO AUTOPSY			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No.	City or Town		County	State	
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from 9/10/68 , 19 68 , to 10/9/68 , 19 68 , that <input type="checkbox"/> (we) last saw the deceased alive on 10/9/68 , 19 68 , and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> (we) did <input type="checkbox"/> did not view the body after death.									
22b. SIGNATURE <i>George C. McElfatrick, M.D.</i>		DEGREE M.D.	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED 10/9/68			
22d. PHYSICIAN'S NAME (Type) GEORGE C. MC ELFATRICK, M. D.		22e. ADDRESS VAH FORT HOWARD, MARYLAND							
23a. BURIAL/CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 10-14-68	23c. NAME OF CEMETERY OR CREMATORIAL BALTIMORE NATIONAL			23d. LOCATION (City or Town) BALTIMORE, MARYLAND	(County) —	(State) —	
24. FUNERAL DIRECTOR <i>Vernon P. Bailey</i>		ADDRESS KELSON FUNERAL HOME			25a. REGISTRY REGISTRAR OCT 11 1968	25b. REGISTRAR'S SIGNATURE <i>George C. McElfatrick, M.D.</i>			
		1348 N. Calhoun St., Baltimore, Md.							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it may be retained by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers from page 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)	First <i>James</i>	Middle <i>E</i>	Last <i>Healy</i>	2a. DATE OF DEATH Month <i>OCT</i>	Day <i>31</i>	Year <i>1968</i>	2b. HOUR
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>JAN 31 1912</i>		6. AGE (In years last birthday) <i>56</i>		7. UNDERR 1 YEAR MONTHS <i>0</i>	
7a. BIRTHPLACE (State or foreign country) <i>Penn</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i>		10. MONTHS <i>0</i>	
10. CITY OR TOWN OF DEATH <i>Towson</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>St. Joseph Hosp</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>F. THER</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Surgical Sup</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <i>ST Md</i>		13b. COUNT <i>BALTIMORE</i>	13c. CITY OR TOWN <i>Parkville</i>	13d. INSIDE CITY LIMITS? <i>NO</i>	13e. STREET AND NUMBER <i>3952 MANN'S Ave</i>		
14. FATHER'S NAME First <i>John</i>	Middle <i>Healy</i>	Last	15. MOTHER'S MAIDEN NAME First <i>MARY</i>	Middle	Last <i>O'connell</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>yes</i>	16b. SOCIAL SECURITY NO. <i>WWE 946 212-03-274</i>	17. INFORMANT <i>JUNE Healy</i>	Address <i>2952 MANN'S Ave</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 WK</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CEREBRAL THROMBOSES</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ARTERIOSCLEROSIS</i> DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>ASCVD</i>							
19a. DATE OF OPERATION <i>2/22/68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <i>19</i> Month <i>Day</i> Year <i>P.M.</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. <i>8100 Hartford Rd</i>	City or Town <i>Baltimore</i>	County <i>Md</i>	State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>P. Berger</i>		DEGREE <i>MD</i>	ATTENDING PHYS <i>L.P. BERGER</i>	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>11/1/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>S. ELLIOT HARRIS</i>		22e. ADDRESS <i>8100 Hartford Rd</i>					
23a. BURIAL, CREMATION, OR INCINERATION <i>BURIAL</i>		23b. DATE <i>11-4-68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Baltimore National</i>	23d. LOCATION (City or town) <i>Baltimore</i>	(County) <i>Md</i> (State)		
24. FUNERAL DIRECTOR <i>Chas. F. Evans Sm</i>		ADDRESS <i>8802 Hartford Rd</i>	25a. REC'D BY REGISTRAR DATE <i>NOV 4 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 23 Film G405 CERTIFICATE OF DEATH

14029

1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH	2b. HOUR
OWEN Raymond HEINTZ						Month Day Year	2b. HOUR
3. SEX	M	4. RACE	W	S. DATE OF BIRTH	4-18-1963	5. AGE (In years last birthday)	10
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED	<input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
Maryland		USA		WIDOWED	<input type="checkbox"/> DIVORCED <input type="checkbox"/>	Balto.	IF UNDER 24 HRS.
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY
Towson		St. Joseph Hospital			child		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER	
Maryland		Baltimore		Timonium		100 Farview Court	
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last
Charles E. Heintz, Jr.				Jean			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes, no, <input checked="" type="checkbox"/> Unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT	
						Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral edema due</u> DUE TO, OR AS A CONSEQUENCE OF <u>to Encephalopathy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) stating the underlying cause (c)							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>18</u>							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION	Street or R.F.D. No.	City or Town	County	State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>10-6</u> , 19 <u>68</u> , to <u>10-12</u> , 19 <u>68</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>10-12</u> , 19 <u>68</u> , and that in <input checked="" type="checkbox"/> (My) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.							
22b. SIGNATURE	Ines Cilliani, M.D.			DEGREE	ATTENDING PHYS	MED DIRECTOR	STAFF PHYS.
22c. DATE SIGNED							
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
Ines Cilliani, M.D.				7620 York Road, Towson 4, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION (City or Town)	(County)	(State)
BURIAL	10/15/68	Dulaney Valley Memorial Gardens			Cockeysville	, Md.	
24. FUNERAL DIRECTOR	ADDRESS			25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE		
John Burns' Sons, Towson, Md.				DATE	OCT 18 1968	Charles Judge	

O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

O FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A15
30M REV



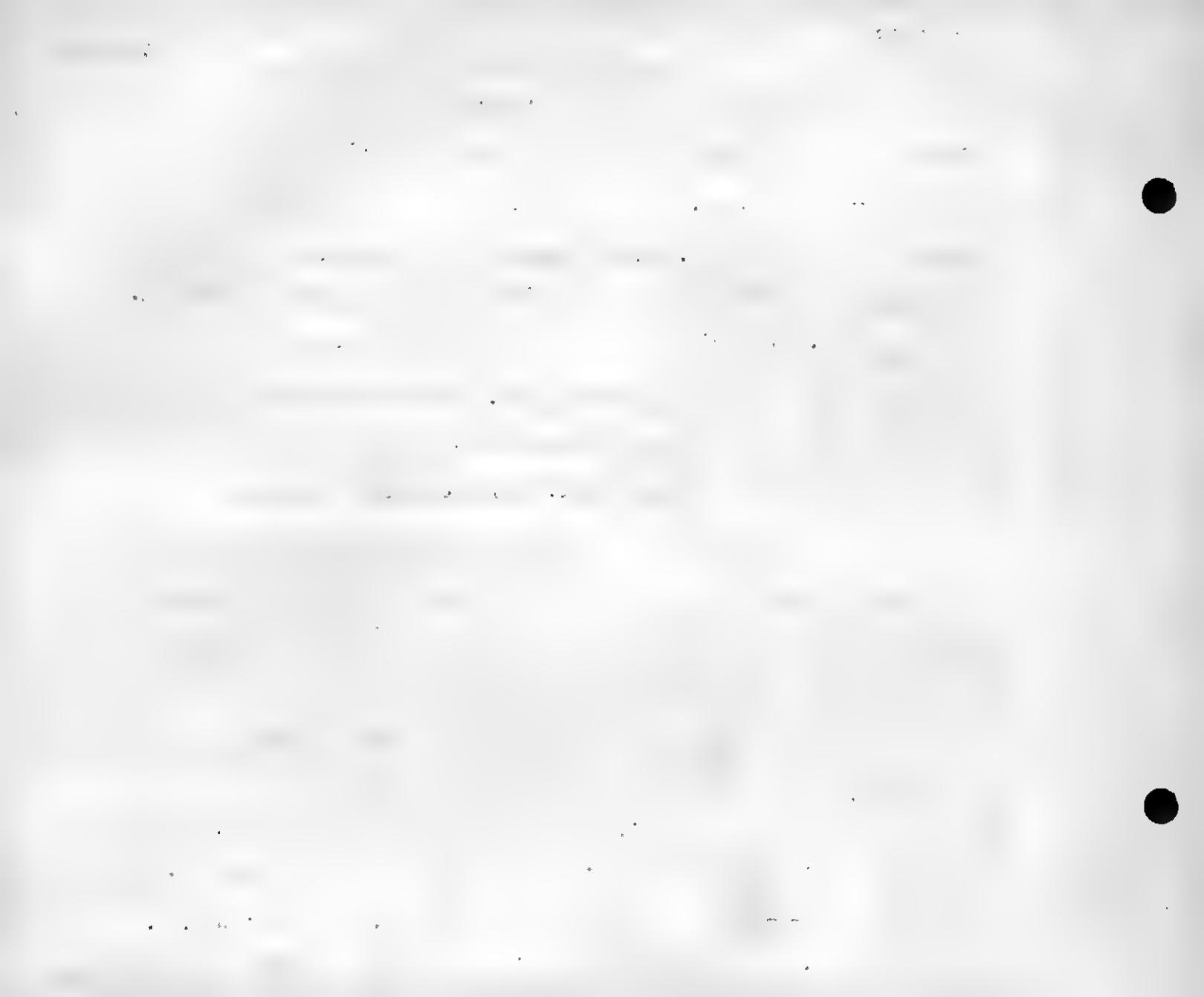
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14030

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First Virginia	Middle Henderson	Last 	2a DATE OF DEATH Month 10	Doy 31	Year 1968	2b HOUR 1:50 P.M.	
3. SEX Female		4. RACE White		S. DATE OF BIRTH June 21, 1897	6 AGE (in years lost birthday) 71 yrs.		IF UNDFTD 1 YEAR MONTHS 	IF UNDFTD 24 HRS. HOURS 	
7a BIRTHPLACE (State or foreign country) West Virginia		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore,				
10 CITY OR TOWN OF DEATH Towson		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Baltimore		13c CITY OR TOWN Baltimore		13d INSIDE CITY L M T S YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER 8804 Chardel Rd.				
14. FATHER'S NAME First John A. Stafford		Middle 	Last 	15. MOTHER'S MAIDEN NAME First Sarah		Middle (unknown)	Last		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b SOCIAL SECURITY NO 233-20-9961		17 INFORMANT Mrs. Charles Henkerick		Address			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral hemorrhage									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4300 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cerebro vascular disease									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> or work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or RFD No	City or Town		County	State	
22a I certify that 10 (this hospital) attended the deceased from 10/31/1968 to 10/31/1968 , that 10 (we) last saw the deceased alive on 10/31/1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Jaime Punzalan, M.D.</i>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c DATE SIGNED 10/31/68				
22d. PHYSICIAN'S NAME (Type) Jaime Punzalan, M.D.		22e ADDRESS 7620 York Rd., Towson, Md. 21204							
23a BURIAL, CREMATION, REMOVAL FROM Charleston		23b DATE 11-2-69		23c NAME OF CEMETERY OR CREMATORIAL Cunningham Memorial Cem.		23d LOCATION (City or Town) Charleston W.Va.		(County) 	(State)
24. FUNERAL DIRECTOR Snodgrass F.H.		ADDRESS 4122 McCorkle Ave			25a. REC'D BY REGISTRAR NOV 4 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14020

CERTIFICATE OF DEATH

14031

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)	First Mary L. Herrick	Middle	Lost	2a. DATE OF DEATH 10/9/68	2b. HOUR 4:30 M
3. SEX F	4. RACE W	S. DATE OF BIRTH 10/16/1881	6. AGE (in years lost birthday) 86	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore		
10. CITY OR TOWN OF DEATH Catonsville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 625 Meyers Drive	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Md	13b. COUNTY Balto.	13c. CITY OR TOWN Catonsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 625 Meyers Dr., 21228	Lost
14. FATHER'S NAME First Henry J. Moseman	Middle	Lost	15. MOTHER'S MAIDEN NAME First Catherine Little	Middle	Lost
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT Mrs. Joseph, 625 Meyers Dr., 21228	Address		
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) Acute myocardial failure 4129</p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) A. S. C. V. disease</p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c)</p>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days					
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)</p> <p>Sensibility</p>					
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
X			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
<p>22a. I certify that (I) (this hospital) attended the deceased from June, 1968, to Oct 9, 1968, that (I) (we) last saw the deceased alive on Oct. 9 1968, and that in my (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.</p>					
22b. SIGNATURE D. C. MacLaughlin	DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 10/11/68	
22d. PHYSICIAN'S NAME (Type) Dr. D. C. MacLaughlin	22e. ADDRESS 303 N. Rolling Road, Baltimore, Md. 21228				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/14/68	23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National	23d. LOCATION (City or Town) Baltimore, Md.	(County)	(State)
24. FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave., 21229	ADDRESS	25a. REC'D BY REGISTRAR OCT 11 1968	25b. REGISTRAR'S SIGNATURE Charles J. George		



14022

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #6, FilmG405 10/18/68 km

CERTIFICATE OF DEATH

14032

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the attending physician, then please remove carbon papers. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH	2b. HOUR
<i>Albert L.</i>		<i>HERRMANN SR</i>		10 Month 9 Day 68 Year	2:30 P.M.
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (In years last birthday) <i>66 07 yrs.</i>	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
<i>M</i>	<i>W</i>	<i>10/21/1901</i>			
7a. BIRTHPLACE (State or Foreign country) <i>Md</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <i>BALTo.</i>		
10. CITY OR TOWN OF DEATH <i>CATONSVILLE</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>SHANGRA LA. Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>FORERMAN</i>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. US/JAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>	13b. COUNTY <i>BALTo.</i>	13c. CITY OR TOWN <i>CATONSVILLE</i>	13d. INSIDE CITY LIMITS <i>YES</i>	13e. STREET AND NUMBER <i>405 Lambeth Rd.</i>	
14. FATHER'S NAME First <i>Emil</i>	Middle	Last <i>HERRMANN</i>	15. MOTHER'S MAIDEN NAME First <i>Helen</i>	Middle	Last <i>VON YON</i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>NO</i>	16b. SOCIAL SECURITY NO <i>213073410A</i>	17. INFORMANT <i>A.L. HERRMANN JR.</i>	Address <i>405 Lambeth Rd</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Carbo vascular (Brombularly) occlusion</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs.</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>Arteriosclerotic Vaso. Disease</i>					
DUE TO, OR AS A CONSEQUENCE OF (b) <i>to left hemiparesis</i>					
DUE TO, OR AS A CONSEQUENCE OF (c) <i>to left hemiparesis</i>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>3 yrs.</i>					
19a. DATE OF OPERATION <i>22-10-68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
				<input type="checkbox"/> YES <input type="checkbox"/> NO	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (HOME FARM STREET FACTORY) OFFICE BUILDING, ETC	21f. LOCATION Street or R.F.D. No	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <i>—</i> , 19 <i>60</i> , to <i>10-9-1968</i> , that (I) (we) last saw the deceased alive on <i>Oct 9 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>J. Nelson McKay MD</i>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED <i>10/10/68</i>
22d. PHYSICIAN'S NAME (Type) <i>J. NELSON MCKAY MD</i>		22e. ADDRESS <i>6014 Edmondson Ave Baltimore Md 21228</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>10/12/68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Schwarts Cemetery</i>	23d. LOCATION (City or Town) <i>BALTo.</i>	(County) <i>Md</i> (State)
24. FUNERAL DIRECTOR <i>E.S. Mae Hall</i>		ADDRESS <i>301 Frederick Rd BALTO. 21228</i>	25a. REC'D BY REGISTRAR DATE <i>OCT 15 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



14022

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14033

DECEASED-NAME (Type or print)		First	Middle	Last	2d. DATE OF DEATH			2b. HOUR	
OSEIAN		E.	HICKMAN		Month	Day	Year	4:12p M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		Caucasian		Dec. 21, 1897		70 yrs		F UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Crisfield, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore			
10 CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balt. Med. Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Assist. Sec.		12b. KIND OF BUSINESS OR INDUSTRY Credit Mgmt.			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN		13d. INSIDE CITY LIMIT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER 156 Dumbarton Rd.		
14. FATHER'S NAME First Wilmer Hickman		Last		15. MOTHER'S MAIDEN NAME First Alice		Middle Last Massey			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown yes		16b. SOCIAL SECURITY NO WW I		17. INFORMANT		Address Mrs. Louise T. Hickman 156 Dumbarton Rd. #12			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive intracerebral hemorrhage						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) _____							
		DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	YES			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from 9/30, 1968 , to 10/9, 1968 , that (I) (we) last saw the deceased alive on 10/9, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Rudiger Breiteneker		DEGREE	ATTENDING PHYS.	<input type="checkbox"/>	MED. DIRECTOR	<input type="checkbox"/>	STAFF PHYS.	<input checked="" type="checkbox"/>	22c. DATE SIGNED 10/10/68
22d. PHYSICIAN'S NAME (Type) Rudiger Breiteneker, M.D.		22e. ADDRESS Greater Baltimore Medical Center							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/12/68	23c. NAME OF CEMETERY OR CREMATORIAL New Cathedral		23d. LOCATION (City or Town) Baltimore, Maryland		(County)	(State)	
24 FUNERAL DIRECTOR Mitchell-Wiedefeld Home		ADDRESS 6500 York Rd. Baltimore, MD 21212		25a. REC'D BY REGISTRAR OCT 17 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers—Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



14023

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 303 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 5 & 6 Film

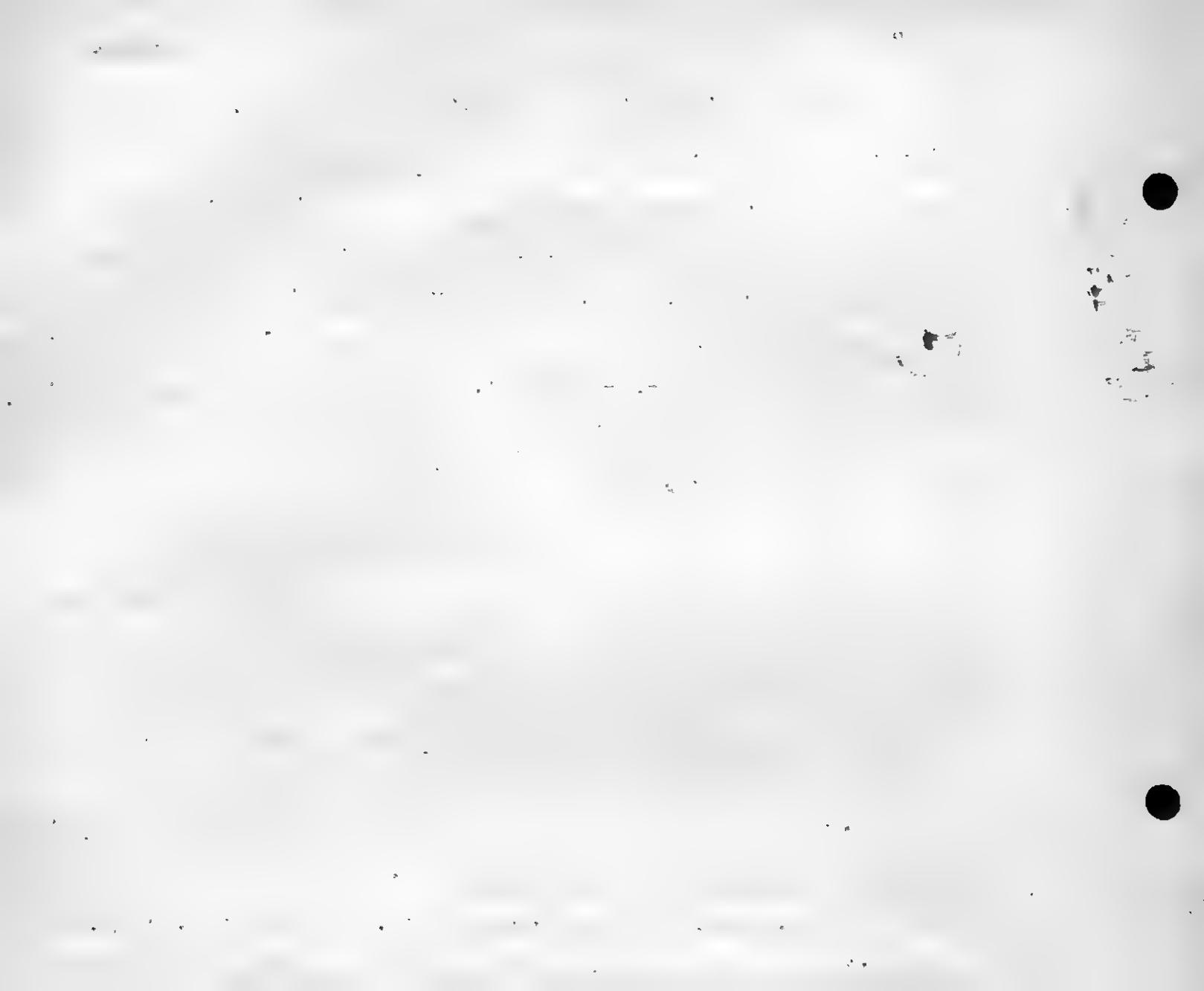
CERTIFICATE OF DEATH

14034

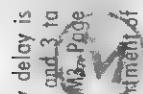
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, file it with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)	First Viola	Middle Christina	Last Hillmeyer	2a. DATE OF DEATH Month Oct. 11, 1968 Day Year 4 pm	2b. HOUR IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
3. SEX Female	4. RACE White	5. DATE OF BIRTH Sept. 19, 1916	6. AGE (In years last birthday) 52 yrs.		
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Bal timore Co., Md.		
10. CITY OR TOWN OF DEATH Reisterstown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 411 Dyer Avenue	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Voucher Clerk	12b. KIND OF BUSINESS OR INDUSTRY Army		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 411 Dyer Avenue		
14. FATHER'S NAME First Frederick	Middle Hillmeyer	15. MOTHER'S MAIDEN NAME First Helen	Middle Eliz. beth	Last Schonberger	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 215-12-8707	17. INFORMANT Mrs. Helen Hillmeyer	Address 411 Dyer Ave., Reisterstown, Md.	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY.</p> <p>IMMEDIATE CAUSE (a) <i>Carcinoma - breast</i> 174X</p> <p>DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p> <p>(b) <i>Metastasis to bone</i> DUE TO, OR AS A CONSEQUENCE OF (c)</p> <p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p> <p>176</p>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUT NG <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from December, 1968, to October 11, 1968, that (I) (we) last saw the deceased alive on October 11, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did-not) view the body after death.					
22b. SIGNATURE <i>C. E. McWilliams, MD</i>		22c. DATE SIGNED October 11, 1968			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 1190 Reisterstown Rd, Reisterstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Oct. 14, 1968	23c. NAME OF CEMETERY OR CREMATORIUM Holy Redeemer Cem.	23d. LOCATION (City or Town) Baltimore, Maryland	(County)	(State)
24. FUNERAL DIRECTOR <i>H. J. Schlaadt</i>		ADDRESS Owings Mills, Md.	25a. REC'D BY REGISTRAR DATE OCT 14 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm 14035. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14035

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)	First DARRELL	Middle (DARRYL)	Last HILTON	2a. DATE KNOWN OF ESTI- MATED	Month 10	Day 20	Year 1968	2b. HOUR M				
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH 26-1952	6. AGE (in years less birthday) 16 yrs	7. IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	IF UNDER 24 HRS HOURS 0	IF UNDER 24 HRS MIN. 0	2c. DATE PRONOUNCED DEAD Month October	Day 20	Year 1968	2d. HOUR 8:30 A.M.	
7a. BIRTHPLACE (State or foreign country) Baltimore		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE						
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Expressway Ruxton Road Overpass		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) School Teacher		12b. KIND OF BUSINESS OR INDUSTRY Public Schools						
13a. USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission) STATE Md.		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY...M.T.P. YES		13e. STREET AND NUMBER 4114 Alton Road						
14. FATHER'S NAME Barney Hilton		First Barney	Middle Hilton	Last 	15. MOTHER'S MAIDEN NAME Josephine Jones	First Josephine	Middle Jones	Last 				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO 64-0216-7005		17. INFORMANT Charles Springate Williams		ADDRESS Sam. A. S. Police		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple severe injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 8151 (b) DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 8194												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH AT WORK		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 7:40 AM 10-20-1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Passenger in auto-fixed object collision								
22a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Expressway		21f. LOCATION Street or R.F.D. No Ruxton Road Overpass		City or Town Baltimore		County Md.				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>Charles S. Springate</i>		EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED October 20, 1968				
23a. BURIAL, CREMAT. ON. REMOVAL (Specify) Burial		23b. DATE 10/23/68		23c. NAME OF CEMETERY OR CREMATORIAL ROUTUS Mort Pk		23d. LOCATION (City or Town) ROUTUS-Baltimore 21227		(County) Baltimore		(State) Md.		
24. FUNERAL DIRECTOR Mars Gar P Hayes		ADDRESS 638 N Calmoe		25a. REC'D. BY REGISTRAR DATE OCT 22 1968		25b. REGISTRAR'S SIGNATURE Charles Springate						



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14025

CERTIFICATE OF DEATH

14036

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First <i>James</i>	Middle <i>Bruce</i>	Last <i>Hoddinott</i>	2a. DATE OF DEATH Month <i>Oct.</i>	2b. HOUR Year <i>6 1968 5:44 P.M.</i>	
3. SEX <i>male</i>	4. RACE <i>white</i>	5. DATE OF BIRTH <i>Nov. 3, 1891</i>		6. AGE (In years last birthday) <i>76</i>	IF UNDER 1 YEAR MONTHS <i>YRS.</i>	IF UNDER 24 HRS. DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>	7b. CIT. ZEN. OF WHAT COUNTRY? <i>USA</i>	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	C. DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Baltimore</i>		
10. CITY OR TOWN OF DEATH <i>Towson</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>347 Yorktowne Drive</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Proprietor</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Steel</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>Baltimore</i>	13c. CITY OR TOWN <i>Towson</i>	13d. INSIDE CITY LIMIT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>7347 Yorktowne Drive</i>		
14. FATHER'S NAME First <i>James Nicholas Hoddinott</i>	Middle <i></i>	Last <i></i>	15. MOTHER'S MAIDEN NAME First <i>Martha Burton</i>	Middle <i></i>	Last <i></i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <i>165019679A</i>	17. INFORMANT <i>Amogene Hoddinott</i>	Address <i>same</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ingestion of alcohol & tobacco</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>						
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 months</i>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4221</i>						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR. CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan. 1, 1968</i> , to <i>Oct. 6, 1968</i> , that (I) (we) last saw the deceased alive on <i>Oct. 6, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.						
22b. SIGNATURE <i>A. Allan Spier</i>	DEGREE <i>M.D.</i>	ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>10/9/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>A. Allan Spier</i>	22e. ADDRESS <i>1501 Penridge Rd.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>10/9/68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Loudon Park Cem.</i>		23d. LOCATION (City or Town) <i>Baltimore, Md.</i>	(County)	(State)
24. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc Baltimore, Md.</i>	ADDRESS	25a. REC'D. BY REGISTRAR <i>OCT 8 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	DATE	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14026

14037

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First ERNEST	Middle CHARLES	Last HOFFMAN	2a. DATE OF DEATH Month 10	Day 24	Year 68	2b. HOUR P.M. 12:30M
3 SEX MALE	4 RACE CAU	5 DATE OF BIRTH 9/3/96	6 AGE (In years last birthday) 72 yrs	IF UNDER 24 HRS MONTHS 0	IF UNDER 24 HRS DAYS 0	IF UNDER 24 HRS HOURS 0	IF UNDER 24 HRS MIN. 0
7a BIRTHPLACE (State or foreign country) D.C.	7b CITIZEN OF WHAT COUNTRY? U. S. A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH BALTIMORE, MARYLAND				
10 CITY OR TOWN OF DEATH Baltimore, Md.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GREAT. BALT. MED. CENT.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Maritime Eng. Shipping	12b. KIND OF BUSINESS OR INDUSTRY 3051 Guilford Ave.				
13a. USUAL RESIDENCE (Where deceased resided, if institution or residence before admission) STATE Md.	13c CITY OR TOWN Baltimore, Baltimore	13d INSIDE CTY. LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER 3051 Guilford Ave.				
14 FATHER'S NAME First Unknown	Middle	Last	15 MOTHER'S MAIDEN NAME First Unknown	Middle	Last		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b SOCIAL SECURITY NO. 566-07-3106	17 INFORMANT Mrs. Stephen Szymanski Address 3015 Hudson St., Baltimore, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (o) CARDIORESPIRATORY FAILURE							
16d 1 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause (b) CA OF LUNG DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) 163x							
19a. DATE OF OPERATION 163x	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No	City or Town	County	State		
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9-25 , 19 68 , to 10-24 , 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10-24 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (did not) view the body after death							
22b. SIGNATURE ER Sonnen	DEGREE ATTENDING PHYS	<input type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 10-24-68			
22d. PHYSICIAN'S NAME (Type) EDWARD R. SOLDIJN	22e ADDRESS 6701 N CHARLES ST BATT. MD						
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE 10/26/68	23c. NAME OF CEMETERY OR CREMATORIAL Greenmount Crematory	23d. LOCATION (City or Town) Baltimore, Md.	(County)	(State)		
24. FUNERAL DIRECTOR Matthews Funeral Home	ADDRESS 3021 Eastern Avenue	25a. REG. NO. 001	REG. STAR 28	REG. YEAR 1968	REG. S. SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14027

14038

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please staple carbon papers. Page 3 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First John	Middle C.	Last Hofmeister	2a. DATE OF DEATH Month October	Doy 27	Year 1968	2b. HOUR 1.50 P.M.	
3. SEX Male	4. RACE White	S. DATE OF BIRTH 3-11-1901	6. AGE (In years lost birthday) 67 yrs	IF UNDER YEAR MONTHS DAYS HOURS MIN.				
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore					
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Prop. Tavern	12b. KIND OF BUSINESS OR INDUSTRY Own					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY (IN TSP) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 6209 York Rd., 21212					
14. FATHER'S NAME First John C. Hofmeister	Middle 	15. MOTHER'S MAIDEN NAME First Sarah Garrison	Middle 	Lost 				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no	16b. SOCIAL SECURITY NO. If yes give war or dates of service _____	17. INFORMANT Mrs. Lillian M. Hofmeister	Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic-vascular heart disease 4127 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
(b) DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4								
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from 10-25-1968 to 10-27-1968, that (I) (we) last saw the deceased alive on 10/27/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Camilo Z. Tomboc		DEGREE ATTENDING PHYS	<input type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 10-27-68			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 7620 York Rd., Towson, Md. 21204						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/30/68	23c. NAME OF CEMETERY OR CREMATORIAL Parkwood Cemetery	23d. LOCATION (City or Town) Baltimore	(County)	(State)			
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home-6500	ADDRESS YORK ROAD-21212	25a. REC'D BY REGISTRAR NOV 1 1968	25b. REGISTRAR'S SIGNATURE Charles Judge					
VR A15 30M REV 10-68								



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14028

14039

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, and 2 copies should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First BEULAH	Middle E.	Last HOLLINS	2a. DATE OF DEATH Month OCT 2	Day 1968	Year 68	2b. HOUR P.M.	
3 SEX F	4. RACE WHITE	S. DATE OF BIRTH 9-22-19	6. AGE (In years last birthday) 89 YRS	F UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	HOURS M.N. 0		
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE Co.					
10. CITY OR TOWN OF DEATH Catonsville	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) House in the Pines	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Baby Sitter	12b. KIND OF BUSINESS OR INDUSTRY Self emp.					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland	13b. COUNTY Anne Arundel	13c. CITY OR TOWN Davidsonville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER --				
14. FATHER'S NAME First Joseph	Middle Stuart	Last Ward	15. MOTHER'S MAIDEN NAME First Georgetta	Middle Jackson	Last 			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO (If give war or dates of service) 212-36-59-531	17. INFORMANT J. Stuart Hollins -	1817 Alt. Vista Ave., Baltimore, Md. 21207					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ?				
DUE TO, OR AS A CONSEQUENCE OF A SCUD								
DUE TO, OR AS A CONSEQUENCE OF (b)								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4129								
19a. DATE OF OPERATION 	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med col examiner) 	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) 						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) 	21f. LOCATION Street or R.F.D. No. 	City or Town 	County 	State 			
22a. I certify that (I) (this hospital) attended the deceased from June 1968 , to Sept 18, 1968 , that (I) (we) last saw the deceased alive on Sept 18, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.						22b. DATE SIGNED Oct 2-68		
22b. SIGNATURE EARL PASS MD	DEGREE MD	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>				
22d. PHYSICIAN'S NAME (Type) EARL PASS MD	22e. ADDRESS 10811 Welches Ave							
23a. BURIAL, CREMATION, RENDOM (Specify) Burial	23b. DATE Oct. 5, 1968	23c. NAME OF CEMETERY OR CREMATORIUM Davidsonville Methodist	23d. LOCATION (City or Town) Davidsonville	(County) A.A.	(State) Md.			
24. FUNERAL DIRECTOR BENJAMIN E. HOPPING HOPPING FUNERAL HOME - ANNAPOLIS, MD.	ADDRESS Bentley B. Hopping	25a. REC'D BY REGISTRAR OCT 4 1968	25b. REGISTRAR'S SIGNATURE Charles Judge					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

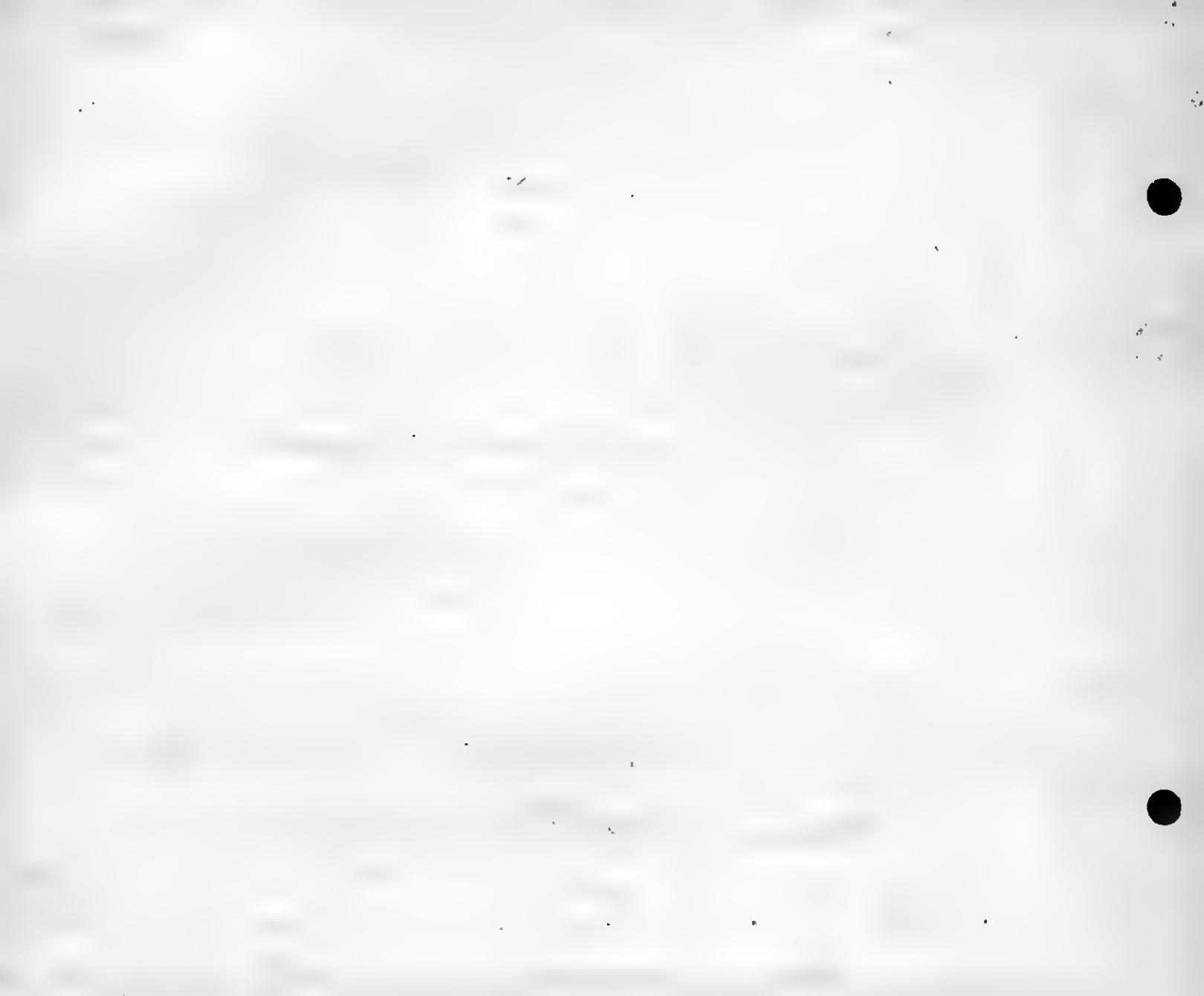
14040

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print) Louise Augusta Hopper			First	Middle	Last	20. DATE OF DEATH Month	Day	Year	2b. HOUR	
3. SEX Female	4 RACE White	5. DATE OF BIRTH 9-2-1880	6 AGE (In years last birthday) 88	IF UNDER 1 YEAR MONTHS 10	IF JUNIOR 24 HRS. DAYS 25	HOURS 14	MIN 25			
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore							
10. CITY OR TOWN OF DEATH Balto. County	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Aged Women's Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.	13b. COUNTY —	13c. CITY OR TOWN Ridgewood	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 5786 Laurel Road						
14. FATHER'S NAME Warren	First	Middle	Last	15. MOTHER'S M AIDEN NAME Louise Augusta	First	Middle	Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO 218 52 2403			17. INFORMANT Louise M. Cook-Brooks	Address 615 Chestnut Ln., House #5a			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 days years		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) acute myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ACCVD DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19c. MEDICAL CERTIFICATION 42		19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERformed			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.			City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from 1956, 19, to 10-25, 1968, that (I) (we) last saw the deceased alive on 10/24/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Neurland 9 Day M.D.		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.			22c. DATE SIGNED October 25, 1968				
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 4-8-33rd St Balto. Md 21218								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-28-68	23c. NAME OF CEMETERY OR CREMATORIAL Green Mount			23d. LOCATION (City or Town) BALTIMORE	(County)	(State) MD		
24. FUNERAL DIRECTOR Wm. Cook-Brooks		ADDRESS 1050 York Rd			25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE Charles Judge				
					DATE OCT 29 1968					



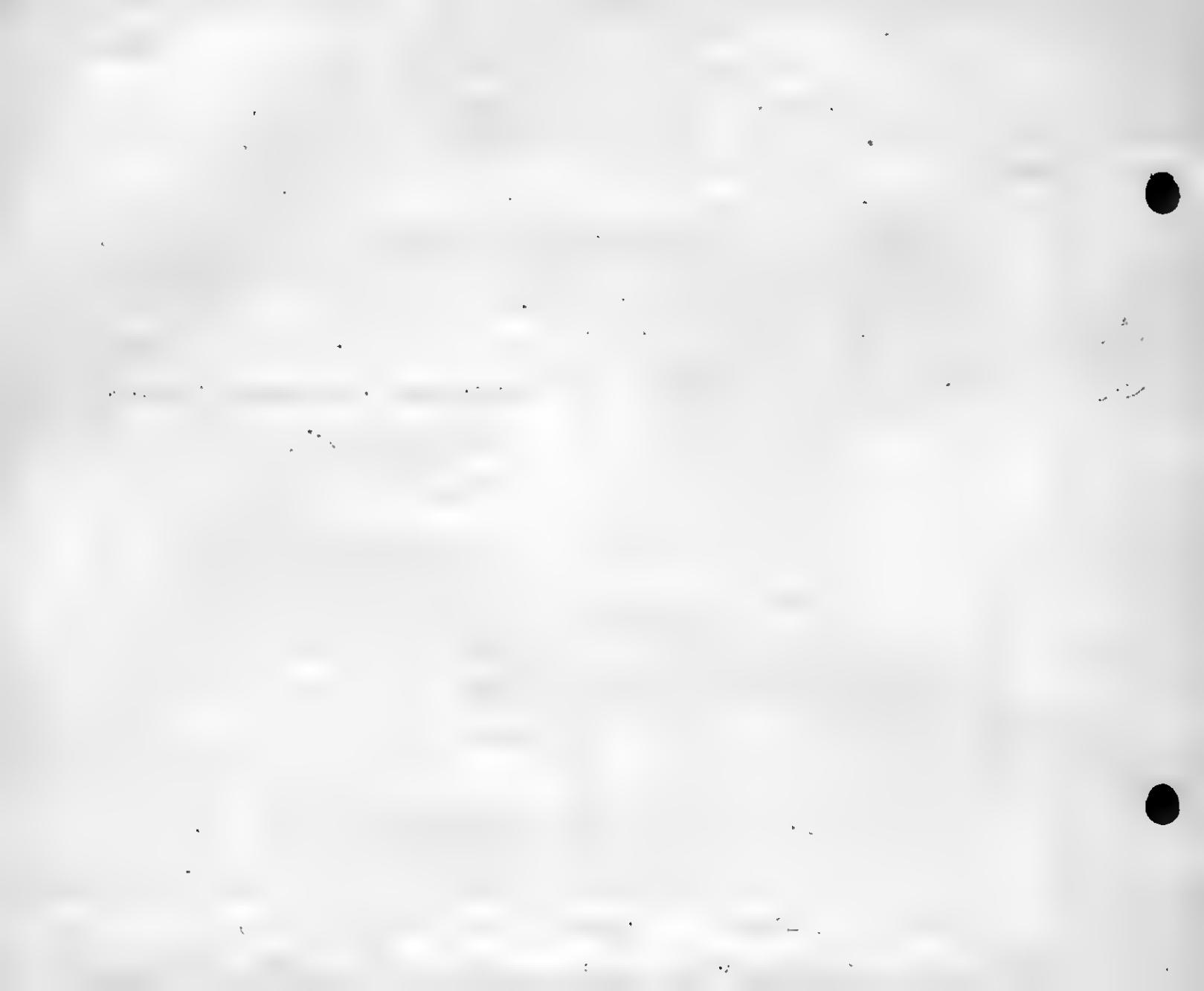
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14041

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death.

Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First <i>Jeanette</i>	Middle	Last <i>Houst</i>	2a. DATE OF DEATH Month <i>Oct</i> Day <i>27</i> Year <i>1968</i>	2b. HOUR M
3 SEX <i>Female</i>	4 RACE <i>White</i>	5. DATE OF BIRTH <i>July 1 1906</i>		6. AGE (in years last b'day) <i>62</i> YRS.		IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i> HOURS <i>0</i> MIN <i>0</i>
7b. BIRTHPLACE (State or foreign country) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore Co</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Dept Store</i>
10. CITY OR TOWN OF DEATH <i>Woodlawn</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>1506 Barrett Rd</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Sales</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md</i>	13b. COUNTY <i>Baltimore</i>	13c. CITY OR TOWN <i>Woodlawn</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>1506 Barrett Rd</i>		
14. FATHER'S NAME First <i>John</i> Middle <i>R</i> Last <i>Stewart</i>		15. MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>Etta</i> Last <i>Parker</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <i>212-26-5680</i>	17. INFORMANT <i>Robert Houst 1506 Barrett Rd Baltimore Md 21207</i>	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Cancer of the uterus</i>		DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause _____ last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 mo.</i>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <i>19</i> Month <i>Oct</i> Day <i>25</i> Year <i>1968</i> P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) <i>at work</i>			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY (OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No <i>5501 Forest Park Ave</i>	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 25, 1968</i> , to <i>Oct 27, 1968</i> , that (I) (we) last saw the deceased alive on <i>Oct 27, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Kennard Yaffe M.D.</i>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>10/28/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>KENNARD YAFFE</i>		22e. ADDRESS <i>5501 Forest Park Ave</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>10-30-68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Baltimore National Cemetery</i>	23d. LOCATION (City or Town) <i>Baltimore, Md</i>	(County)	(State)
24. FUNERAL DIRECTOR <i>Thomas J Kenny Inc</i>		ADDRESS <i>1600 Hollins St</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
DATE <i>OCT 29 1968</i>						



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

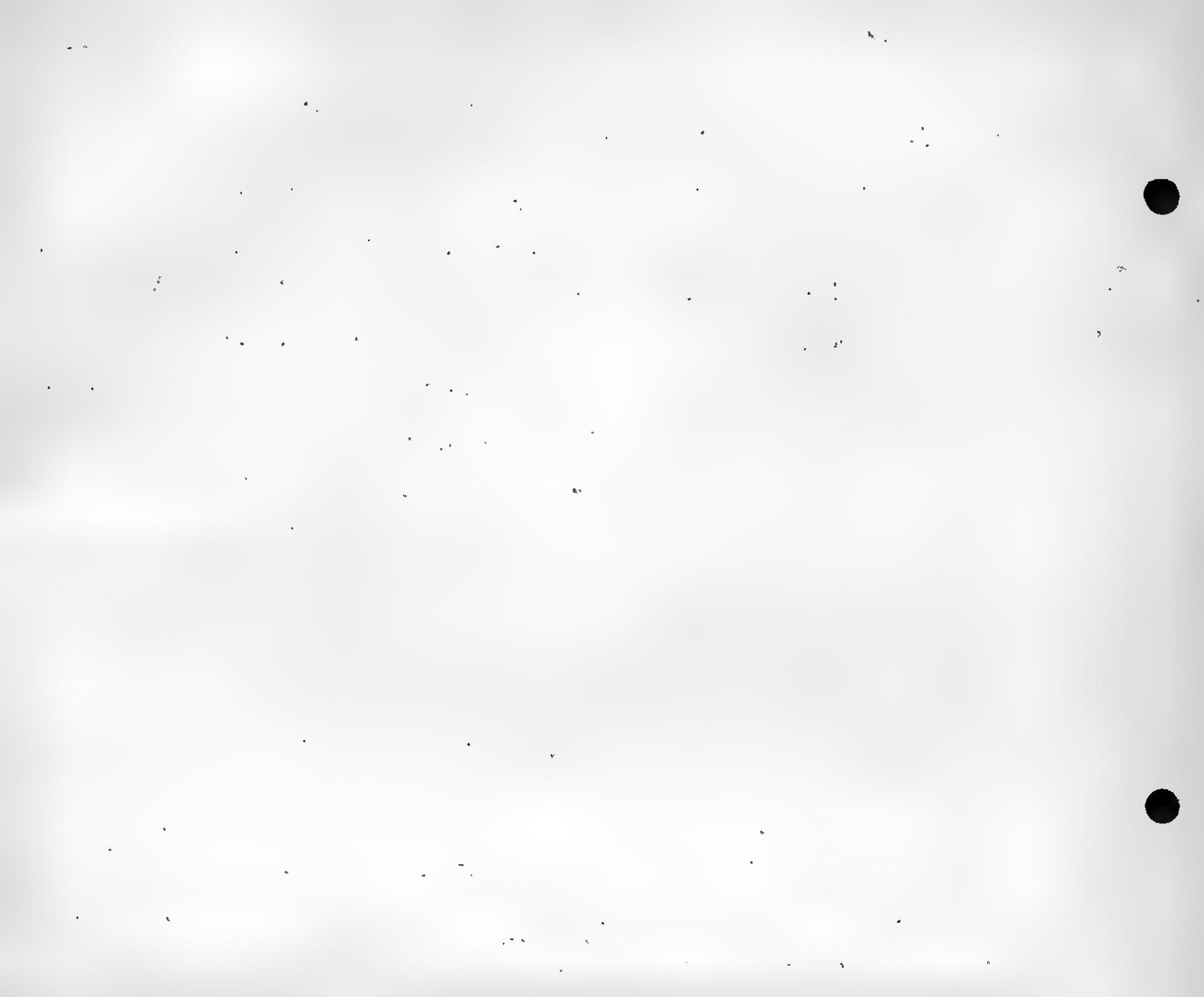
CERTIFICATE OF DEATH

14042

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First <i>Julia</i>	Middle <i>M.</i>	Last <i>Howard</i>	2a. DATE OF DEATH Month <i>Oct</i>	2b. HOUR <i>1408</i>
3 SEX <i>Fe</i>		4. RACE <i>White</i>	5. DATE OF BIRTH <i>2-3-1883</i>		6. AGE (In years last birthday) <i>85</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. Md.
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i>	
10. CITY OR TOWN OF DEATH <i>Garrison, MD</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Torleight Convalescent Center</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Homemaker</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>BALTO</i>	13c. CITY OR TOWN <i>Cockeysville</i>	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>24 G BRONS Blvd 21030</i>	
14. FATHER'S NAME <i>Joshua</i>		Middle <i>GREEN</i>	15. MOTHER'S MAIDEN NAME <i>Mary Elizabeth Martin</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO <i>219-14-2303</i>		17. INFORMANT <i>MRS Edna Warner</i>	Address <i>246 BBONS Blvd</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial ischemia</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> <i>41a</i> (b) <i>Arterial cardiovascular disease - left LVI</i> DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>7-11</i>						
MEDICAL CERTIFICATION		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a I certify that (I) (this hospital) attended the deceased from <i>8-28</i> , 19 <i>68</i> , to <i>10-20</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>10-20</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Vicente M Ruano MD</i>		DEGREE <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>10-20-68</i>			
22d. PHYSICIAN'S NAME (Type) <i>VICENTE M RUANO</i>		22e. ADDRESS <i>Spring Run State Hospital</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>10-23-68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>MUNKTON</i>	23d. LOCATION (City or Town) <i>MUNKTON</i>	(County) <i>Md.</i>	(State)
24. FUNERAL DIRECTOR <i>Wm Cook - Brooks Towson Towson Md 21204</i>		ADDRESS <i>1050 YORK RD</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
		DATE <i>OCT 22 1968</i>				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

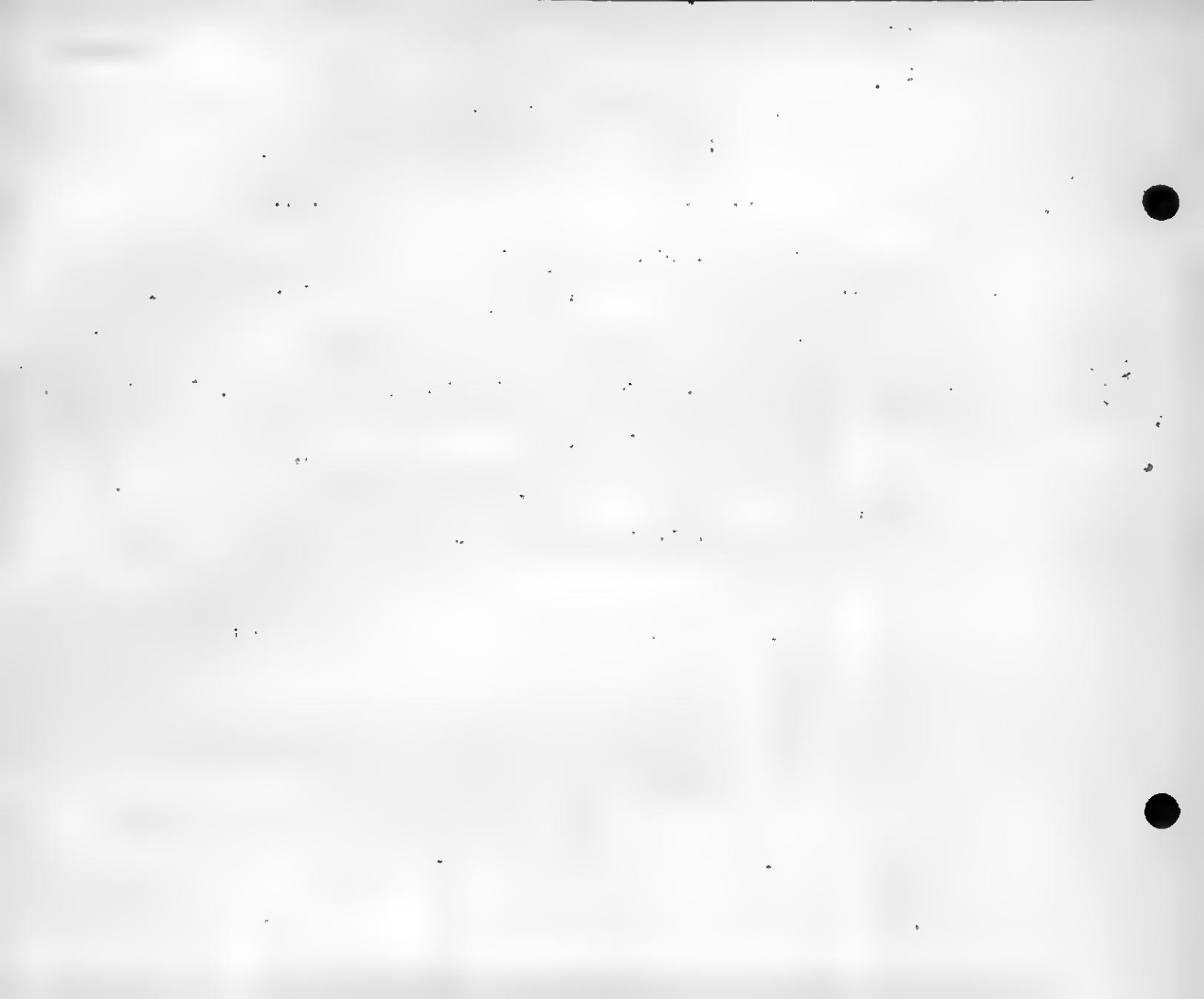
14043

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be ~~be~~ ^{be} certified within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED - NAME (Type or print)				First WILLIAM	Middle BOWEN	Last HUDSON	2a. DATE OF DEATH Month 10	Day 20	Year 68	2b. HOUR 6:00PM
3 SEX MALE		4 RACE WHITE	S. DATE OF BIRTH 4/16/05	6. AGE (In years lost/birthday) 63 YRS		IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH BALTIMORE						
10 CITY OR TOWN OF DEATH FORT HOWARD		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VET. ADM. HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) BARTENDER		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased admission) STATE MARYLAND		13b. COUNTY - - -	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 700 HARVEY STREET					
14 FATHER'S NAME First JOHN		Middle HUDSON	Last	15. MOTHER'S MAIDEN NAME First CECILIA	Middle	Last O'CONNELL				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input checked="" type="checkbox"/> No, <input type="checkbox"/> <small>(If yes, give rank, dates of service)</small> YES		16b. SOCIAL SECURITY NO 217 09 90 31	17 INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		SEPTICEMIC SHOCK			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 DAYS					
1533 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF HEPATIC FAILURE (LAENNEC'S CIRRHOSIS)			1 WEEK					
		DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF SIGMOID COLON			UNKNOWN					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)										
19a. DATE OF OPERATION 10/4/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA OF THE SIGMOID			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no autopsy				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <small>(If either, notify medical examiner)</small>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County		State		
22a. I certify that (I) (we) attended the deceased from 7/15/68 , 19_____, to 10/20/68 , 19_____, that (I) (we) last saw the deceased alive on 10/20/68 , 19_____, and that in 7/15 (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) <input type="checkbox"/> view the body after death.										
22b. SIGNATURE <i>George C. McElfatrick, M.D.</i>		DEGREE MD	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED 10/21/68				
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS VAH FORT HOWARD, MARYLAND								
23a. BURIAL, CREMATION, BURNING (Type)		23b. DATE 10/24/68	23c. NAME OF CEMETERY OR CREMATORIAL BALTIMORE NATIONAL	23d. LOCATION (City or Town) BALTIMORE, MARYLAND		(County)		(State)		
24. FUNERAL DIRECTOR <i>John L. Lee, Esq.</i>		ADDRESS MC GULLY FUNERAL HOME 134 E. Fort Ave. Baltimore Md.	25a. REC'D BY REGISTRAR OCT 28 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					
VR A154 3DM REV 3/68										



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14038

14044

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Page 4 may be retained by the hospital or attending physician.

1. DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH 10 Month 30 Day 68 Year	2b. HOUR 1230 P.M.
Minnie G Hutchins.					
3. SEX Female	4 RACE white	5. DATE OF BIRTH Oct. 1, 1869		6. AGE (In years last birthday) 99 yrs	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) MD	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore Co.		
10. CITY OR TOWN OF DEATH Catonsville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Summit Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY 823 STAMFORD RD
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 823 STAMFORD RD	
14. FATHER'S NAME Joseph F. Campbell	First	Middle	Last	15. MOTHER'S MAIDEN NAME MARY JANE Young	Address MRS BESSIE WEEKS 823 STAMFORD RD
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No	16b. SOCIAL SECURITY NO	17. INFORMANT	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) SQUAMOUS CELL CARCINOMA LEFT CHEEK AND LEFT URIBIT DUE TO, OR AS A CONSEQUENCE OF CHEECK AND LEFT URIBIT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>6/23</u> , 1968, to <u>10/30</u> , 1968, that (I) (we) last saw the deceased alive on <u>10/29</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death					
22b. SIGNATURE E. Kasaitis, M.D.		DEGREE ATTENDING PHYS	22c. DATE SIGNED 10/30/68		
22d. PHYSICIAN'S NAME (Type) E. Kasaitis, M.D.		22e. ADDRESS 1801 (FREDERICK 202) BALTIMORE 21228			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11-2-1968	23c. NAME OF CEMETERY OR Crematory Loudon Park	23d. LOCATION (City or Town) BALTIMORE	(County) MD.	(State)
24. FUNERAL DIRECTOR J. H. House & Son	3327 FORT ST. BALTIMORE	25a. RECD' BY REGISTRAR NOV 4 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		



**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

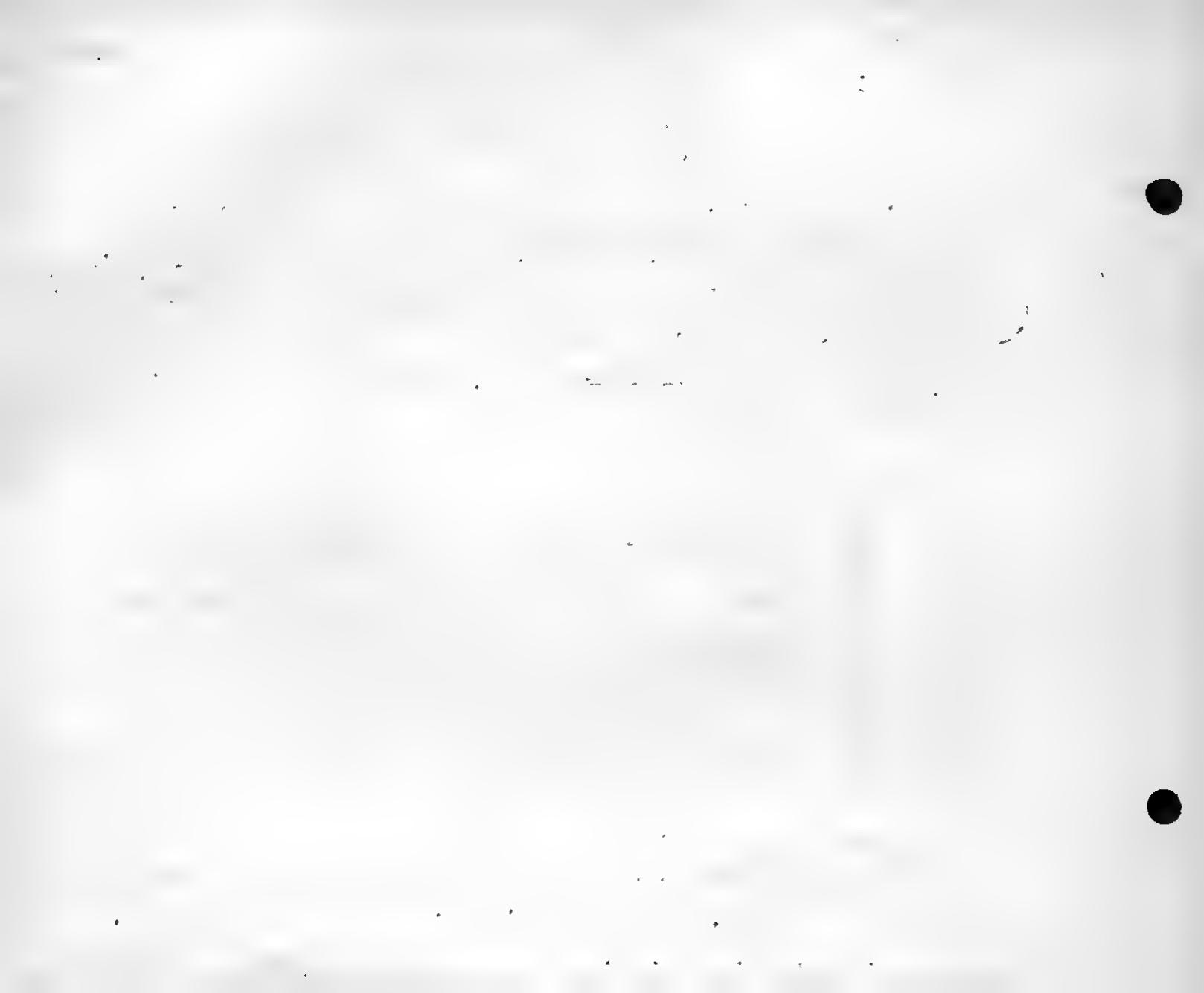
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

NO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon/papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First Emma			Middle R.	Last Hutchinson	2a. DATE OF DEATH Month October 26 1968	2b. HOUR 8:10 P.M.	
3. SEX Female	4. RACE White	5. S. DATE OF BIRTH 10-12-1887			6. AGE (In years last birthday) 81 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore, Md.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Saleslady		12b. KIND OF BUSINESS OR INDUSTRY Dept. Store	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Essex	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 19 E. Midland Rd #20	
14. FATHER'S NAME First Robert		Middle Hutchinson	15. MOTHER'S MAIDEN NAME Unknown			Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 182-09-5538		17. INFORMANT Mrs. Vivian Mattingly Address (Same)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <u>Broncho-pneumonia</u> <u>551.3</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost (b) <u>Hiatal Hernia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Esophageal Rupture</u>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(o)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>10/26/1968</u> to <u>10/26/1968</u> , that (I) (we) last saw the deceased alive on <u>10/26/1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Ines Cilliani</u>		DEGREE ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 10/27/68		
22d. PHYSICIAN'S NAME (Type) Ines Cilliani, M.D.		22e. ADDRESS 7620 York Rd., Towson, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/30/68.	23c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cemetery		23d. LOCATION (City or Town) Baltimore, Md.	(County) (State)	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214			25a. REC'D BY REGISTRAR DATE OCT 28 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

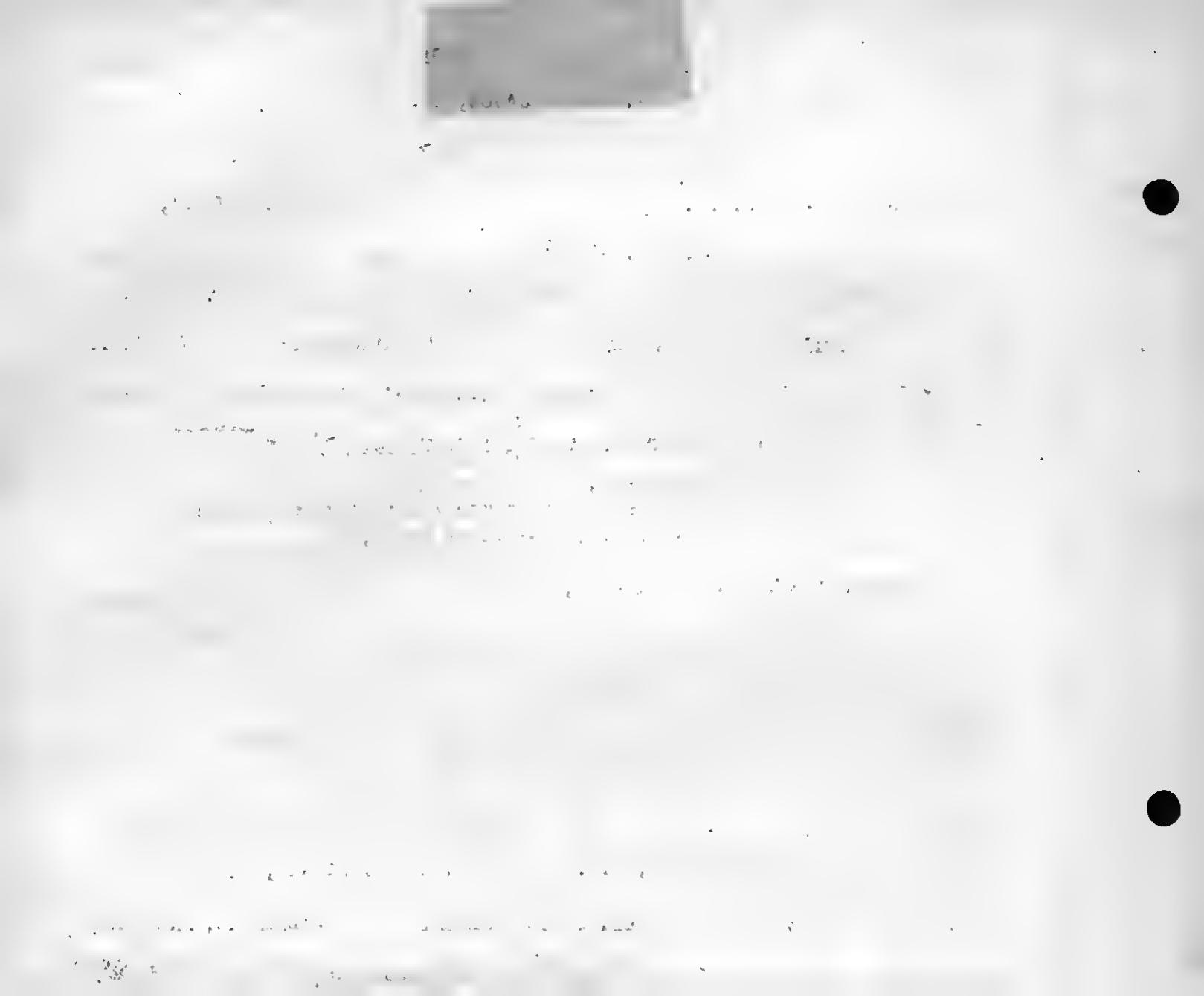
CERTIFICATE OF DEATH

14035

14046

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transtil permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First PAUL	Middle F.	Last JACOB, SR.	2a. DATE OF DEATH Month 10	Day 7	Year 68	2b. HOUR 2:35 P M		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 6/1/92		6. AGE (in years last birthday) 76 YRS.		IF UNDER 1 YEAR MONTHS 0	F. UNDER 24 HRS HOURS 0	MIN 0
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE COUNTY,				
10. CITY OR TOWN OF DEATH FORT HOWARD		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VET. A.M. HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) BAKER		12b. KIND OF BUSINESS OR INDUSTRY BAKERY				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 418 N. Bend Road				
14. FATHER'S NAME First LOUIS		Middle JACOB	Last	15. MOTHER'S MAIDEN NAME First MARGARETTE		Middle	Last DETTRICH			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES		16b. SOCIAL SECURITY NO (If yes give war or dates of service) WW I 005 32 84 41		17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address				
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, RECENT DUE TO, OR AS A CONSEQUENCE OF ADENOCARCINOMA PROSTATE WITH HEMORRHAGE, OLD AND RECENT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 1977</p> <p>(b) METASTATIC ADENOCARCINOMA, PELVIC WALL AND REGIONAL LYMPH NODES, OLD</p> <p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)</p> <p>ARTERIOSCLEROTIC HEART DISEASE, OLD</p>										
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State	
22o. I certify that (X) (this hospital) attended the deceased from 9/20/68 , 19, to 10/1/68 , 19, that (X) (we) last saw the deceased alive on 10/7/68 , 19, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.										
22b. SIGNATURE 		22c. DATE SIGNED 10/8/68								
22d. POSITION (Name/Type)		22e. ADDRESS VAH FORT HOWARD, MARYLAND								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 10/11/68		23c. NAME OF CEMETERY OR CREMATORIUM HOLY CROSS CEMETERY		23d. LOCATION (City or Town) BALTIMORE, MARYLAND		(County) (State)		
24. FUNERAL DIRECTOR		ADDRESS 4101 WITZKE FUNERAL HOME EDMONDSON AVE., BALTIMORE, MD.		25a. REC'D BY REGISTRAR 061		25b. REGISTRAR'S SIGNATURE 				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14035

CERTIFICATE OF DEATH

14047

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. **Page 3 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.**

1. DECEASED NAME (Type or print)		First IDA	Middle	Last JAFFE	2a. DATE OF DEATH Month OCTOBER	Day 16	Year 1968	2b. HOUR 1:30 A.M.
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH APRIL 1899		6. AGE (In years last birthday) 69	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) BALTIMORE, MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE					
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3104 FAIRVIEW ROAD			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED		12b KIND OF BUSINESS OR INDUSTRY SALES LADY		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b. COUNTY BALTIMORE	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER 3104 FAIRVIEW ROAD				
14. FATHER'S NAME First HARRIS	Middle LUNTZ	Last	15. MOTHER'S MAIDEN NAME First LENA	Middle	Last ?			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO	16b. SOCIAL SECURITY NO. 216-16-9328	17. INFORMANT MRS. ANNETTE STEEL, 3104 FAIRVIEW RD. #21207	Address					
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 41d DUE TO, OR AS A CONSEQUENCE OF COXONARY HEART DISEASE						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 YRS?		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause COXONARY ATHEROSCLEROSIS						?		
DUE TO, OR AS A CONSEQUENCE OF (b) DIABETES MELLITUS						2 yrs		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)								
19a. DATE OF OPERATION NONE		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from 1-20 , 19 68 , to 10-16 , 19 68 , that (I) (we) last saw the deceased alive on 10-8 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Leon Ashman M.D.</i>		DEGREE M.D.	ATTENDING PHYS <input checked="" type="checkbox"/> DIRECTOR	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 10-17-68			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 5907 GUYNNS OAK AVENUE						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 10-17-68	23c. NAME OF CEMETERY OR CREMATORIUM ANSHE NESNIA		23d. LOCATION (City or Town) ROSEDALE, MARYLAND (County) (State)			
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		ADDRESS	25a. REC'D BY REGISTRAR DATE OCT 21 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14037

14048

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers from pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First MARY	Middle L.	Last JAMES	2a. DATE OF DEATH Month October	Day 26	Year 1968	2b. HOUR 12:35 AM				
3 SEX Female		4 RACE White	5. DATE OF BIRTH Dec. 9, 1889		6. AGE (In years 78 yrs)		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED		9. COUNTY OF DEATH Baltimore							
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMIT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 263 Rogers Forge Rd.						
14. FATHER'S NAME First Charles		Middle A.	Last Singewald	15. MOTHER'S MAIDEN NAME First Catherine		Middle Wessling	Last Glen Burnie, Md. NE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO (If yes give war or dates of service) 212-10-8353D		17. INFORMANT John A. James, 606 Washington Ave.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) <table border="0" style="width: 100%;"> <tr> <td colspan="2">PART I. DEATH WAS CAUSED BY:</td> <td rowspan="2" style="vertical-align: middle; text-align: right; width: 10%;">APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</td> </tr> <tr> <td colspan="2"> IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>731.0</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF <u>lost</u> <u>Generalized Arteriosclerosis</u> </td> </tr> </table>								PART I. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>731.0</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF <u>lost</u> <u>Generalized Arteriosclerosis</u>	
PART I. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>731.0</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF <u>lost</u> <u>Generalized Arteriosclerosis</u>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 331.x												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year PM 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State					
22a. I certify that (I) (this hospital) attended the deceased from <u>10-25-68</u> , 19 <u>68</u> , to <u>10-26</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>10-26</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Beatriz P. Diszon</i>		DEGREE ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 10-26-68							
22d. PHYSICIAN'S NAME (Type) Beatriz P. Diszon, M.D.		22e. ADDRESS St. Joseph's Hospital										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/29/68	23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park		23d. LOCATION (City or Town) Baltimore (County) (State) Md.							
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Rd. Baltimore, Md.	25a. REC'D BY REGISTRAR DATE OCT 28 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

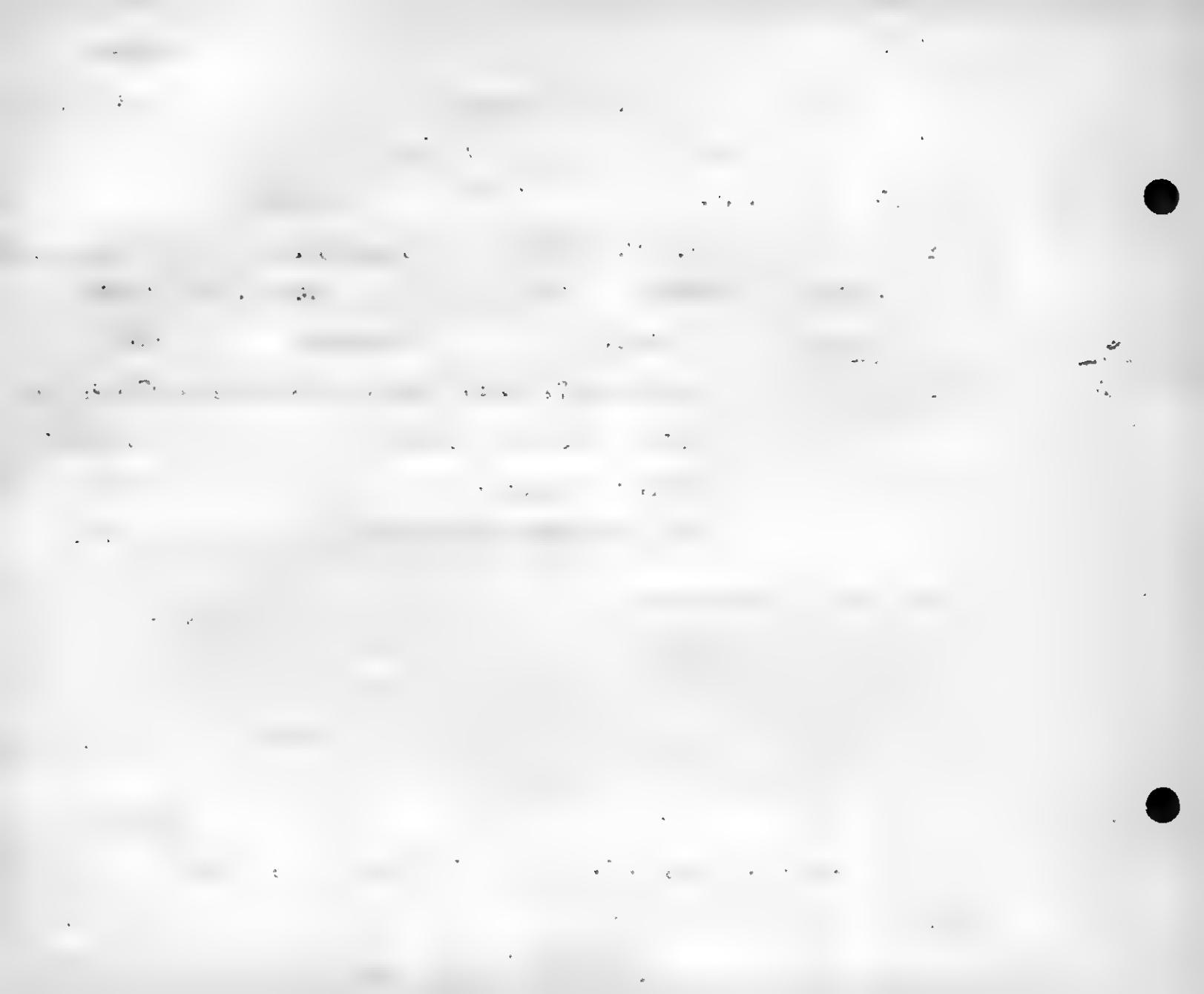
CERTIFICATE OF DEATH

14038

14049

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
11 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician. Then please remove carbon papers. 1 and 2
 director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. 1 and 2
 and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)		First DAVID	Middle Howard	Lost JOESTING	2a. DATE OF DEATH Month 10	Day 1	Hour 8:00	2b. HOUR 8:20AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 8/17/14		6. AGE (In years last birthday) 54 YRS.			
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE			
10. CITY OR TOWN OF DEATH FORT HOWARD		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VET. ADM. HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CONSTRUCTION			12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		
13a. USUAL RESIDENCE (Where deceased lived, if instit on admission) STATE MARYLAND		13b. COUNTY HARFORD		13c. CITY OR TOWN BEL AIR		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1401 S. KELLY AVENUE	
14. FATHER'S NAME First WILLIAM		Middle JOESTING	Lost	15. MOTHER'S MAIDEN NAME First ELIZABETH		Middle	Last FOUTZ		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no; unknown) YES		16b. SOCIAL SECURITY NO WW II		17. INFORMANT 574 03 96 79 CLIN.RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		PASSIVE CONGESTION OF HEART							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 MONTHS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause 511a		DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC COR PULMONALE							YEARS
		DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC OBSTRUCTIVE LUNG DISEASE							YEARS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 511b									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO AUTOPSY		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9/23/68 , 19 19 , to 10/1/68 , 19 19 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10/1/68 , 19 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Peter V. Juvan</i>		DEGREE M.D.	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED 10/1/68			
22d. PHYSICIAN'S NAME (Type) PETER V. JUVAN, M. D.		22e. ADDRESS VAH FORT HOWARD, MARYLAND							
23a. BURIAL, CREMATION, BURIAL (Specify) BURIAL		23b. DATE October 3, 1968		23c. NAME OF CEMETERY OR CREMATORIAL BEL AIR MEMORIAL GARDENS		23d. LOCATION (City or Town) BEL AIR, HARFORD CO., MARYLAND 21014		(County)	(State)
24. FUNERAL DIRECTOR <i>John Foster</i>		ADDRESS FOSTER FUNERAL HOME		25a. REC'D BY REGISTRAR OCT 13 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
		W. FOSTER , BEL AIR, MD. 21014							



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

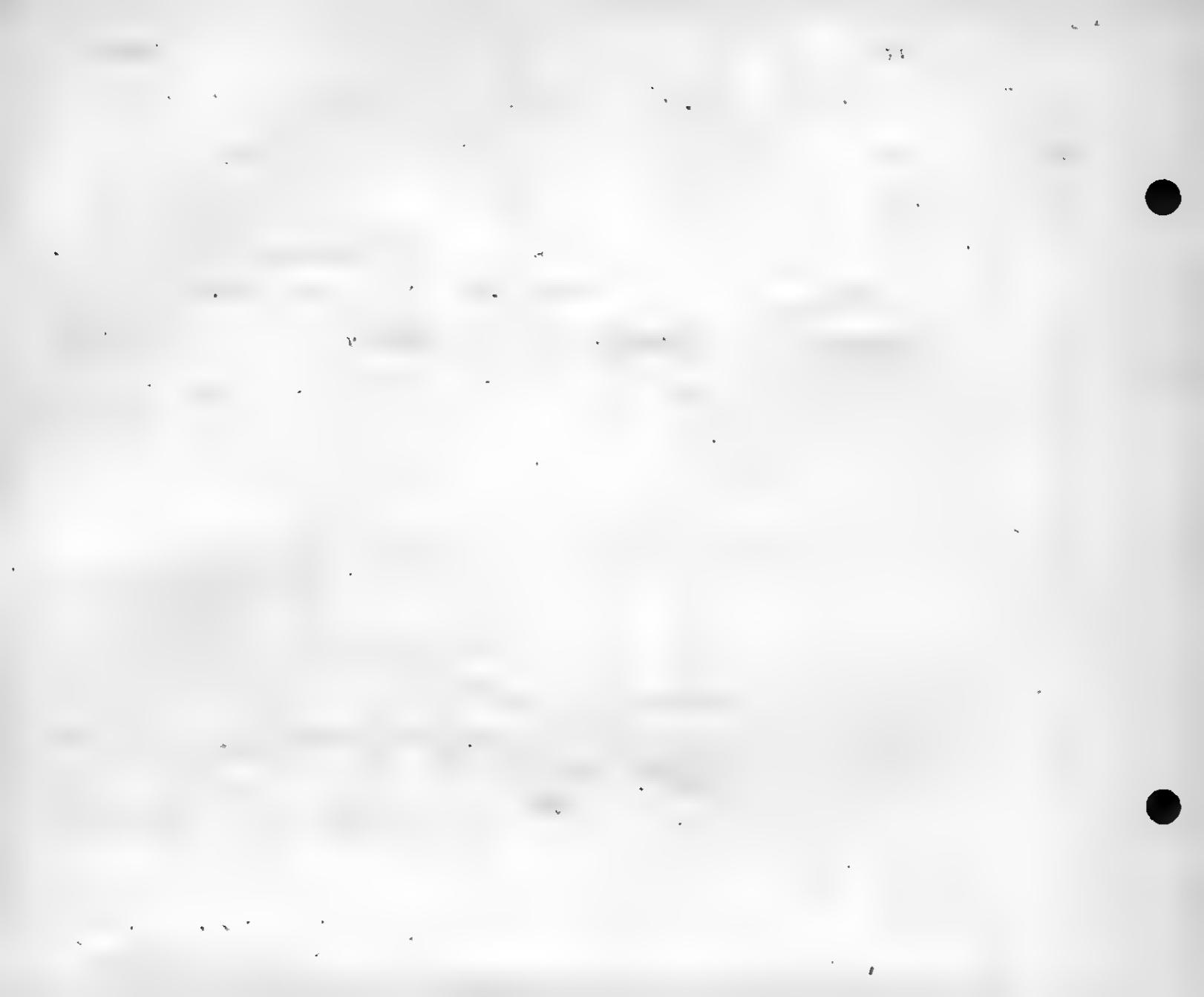
14038

14050

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First DAVID JESSE	Middle JOHNSON	Last JOHNSON	2a. DATE OF DEATH Oct Month 9 Doy 1968	2b. HOUR 6:30 P.M.	
3. SEX MALE		4. RACE NEGRO	5. DATE OF BIRTH 9/22/1917		6. AGE (in years last birthday) 71 YRS.	IF UNDER MONTHS YEAR IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MD		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County		
10. CITY OR TOWN OF DEATH Mount Wilson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mount Wilson State Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) REPAIRMAN		12b. KIND OF BUSINESS OR INDUSTRY FURNITURE	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1027 BENNETT PLACE		
14. FATHER'S NAME First RICHARD		Middle JOHNSON	15. MOTHER'S MAIDEN NAME First MARY		Middle JACKSON	Last JACKSON	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO 215-18-5760	17. INFORMANT Records, Mount Wilson State Hospital		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmon Artery emptyema APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 492X							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 5271							
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ROMAN pulm. art. thrombo embolus, esp. pulm. TB, (n.c.)							
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 43		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 Month Day Year P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) 19				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. Arbutus Memorial Park	City or Town Baltimore Co., Maryland	County Baltimore Co.	State Maryland	
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from 7/29/68 , to 9 Oct 1968 , that <input type="checkbox"/> (we) last saw the deceased alive on 9 Oct 1968 , and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> (we) (did) <input type="checkbox"/> (did not) view the body after death.							
22b. SIGNATURE William Newcomer		22c. DEGREE M.D.	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22d. DATE SIGNED 9 Oct 1968	
22e. PHYSICIAN'S NAME (Type) William Newcomer, M.D.		22e. ADDRESS Mount Wilson, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/14/68	23c. NAME OF CEMETERY OR CREMATORIAL Arbutus Memorial Park		23d. LOCATION (City or Town) Baltimore Co., Maryland	(County) Baltimore Co.	(State) Maryland
24. FUNERAL DIRECTOR Herbert E. Nutter-205 W. North Ave.		ADDRESS		25a. REC'D. BY REGISTRAR OCT 15 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

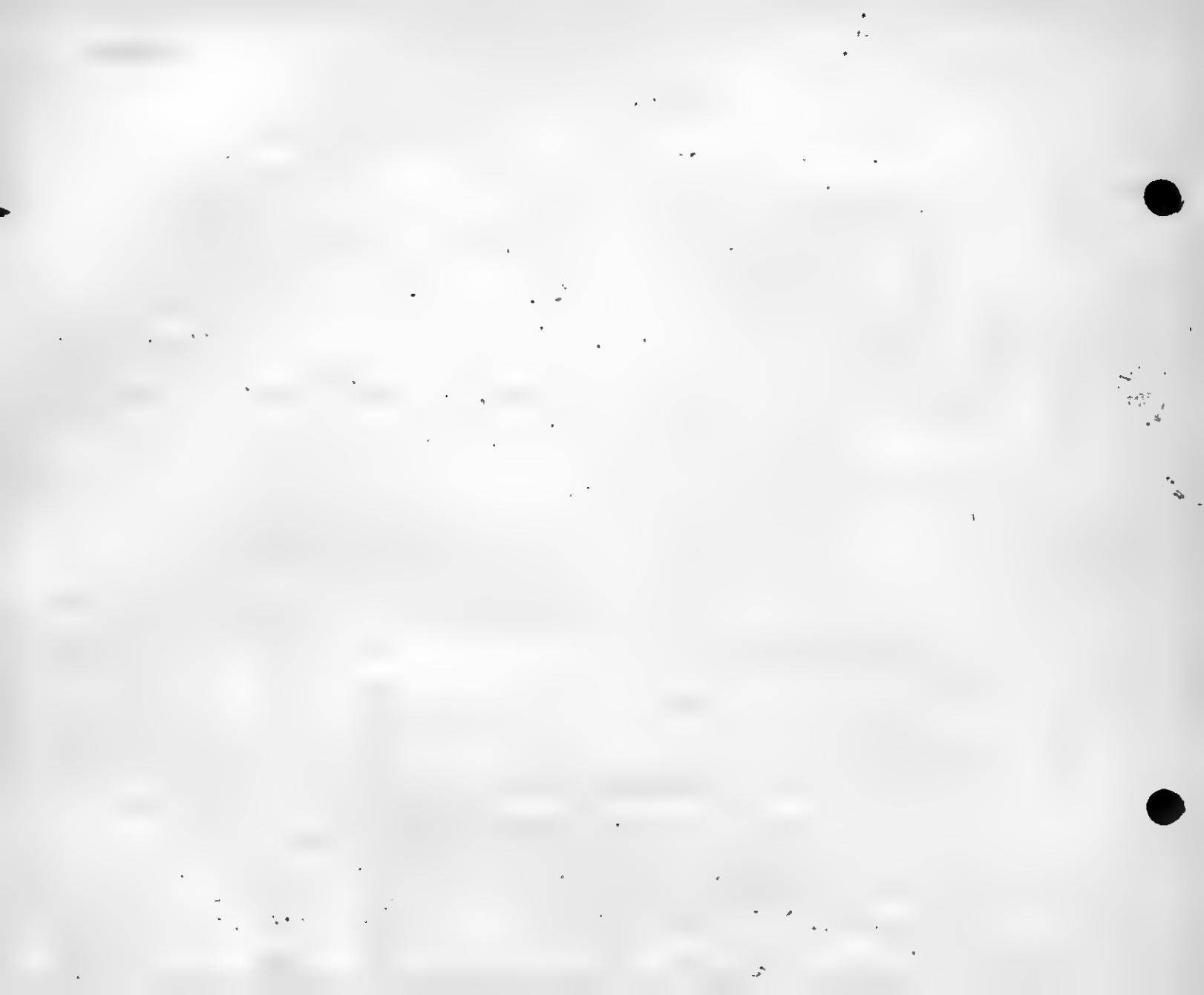
CERTIFICATE OF DEATH

14051

1. DECEASED-NAME (Type or print)		First EVA	Middle NMN	Last JOHNSON	2a. DATE OF DEATH Month 10	Doy 968	Year 1968	2b. HOUR 12:50M	
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH 9-9-1925		6. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Baltimore		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED WIDOWED		9. COUNTY OF DEATH Baltimore			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balt. Med. Center		12a. USUA. OCCUPATION (Kind of work done during past of working life, even if retired.) Domestic		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md		13c. CITY OR TOWN City		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 305 E Lanvale St			
14. FATHER'S NAME James		First R	Middle Mark	Last Lucy	15. MOTHER'S MAIDEN NAME First Thornton	Middle Address Juanita Thompson 414 Pitman Place	Post		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes/no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				Juanita Thompson 414 Pitman				20 hours	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Intracerebral hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
MEDICAL CERTIFICATION		19a. DATE OF OPERATION 12/31/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from 9/30, 1968, to 10/1, 1968, that (I) (we) last saw the deceased alive on 10/1, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Charles C. Brown, M.D.		22c. DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/>		MED DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>	DATE SIGNED 10/1/68
22d. PHYSICIAN'S NAME (Type) Charles C. Brown, M. D.		22e. ADDRESS Greater Baltimore Medical Center							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 10-5-68		23b. DATE 10-5-68		23c. NAME OF CEMETERY OR CREMATORIAL Calvary Cemetery		23d. LOCATION (City or Town) Baltimore		(County) Md	(State)
24. FUNERAL DIRECTOR Raymond Sanders 2177 Partie		ADDRESS ADDRESS		25a. REC'D BY REGISTRAR DATE OCT 8 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours of death.



1

**FOR STATE
HEALTH DEPT.**

1 Items 18, 22a film 406 MARYLAND STATE DEPARTMENT OF HEALTH
1-12-68 mt DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14041 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14052

1 DECEASED NAME (Type or Print)				First	Middle	Last	2a DATE KNOWN OF ESTI- DEATH MATEDX	Month	Day	Year	2b HOUR UNK M	
				MALCOLM	E.	JOHNSON	10/25/68	19				
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD				2d HOUR 8:02 p.m.	
male	white	April 7th, 1929	39 yrs	MONTHS	DAYS	HOURS	Month	Day	Year			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH					
Baltimore, Md		USA					Baltimore					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. JEWISH OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR RECORDED CHILDRED ASSN.	
XXXXXX Towson				St. Joseph's Hospital				Exec. Dir.				
13a. USUAL RESIDENCE (Where deceased resided, if institution before death) STATE Maryland				13c CITY OR TOWN		13d INSIDE CITY LIMITS Govans	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER		1030 Marlow Drive	
14 FATHER'S NAME				First	Middle	Last	15. MOTHER'S MAIDEN NAME				Marjorie Fillmore	
Malcolm D. Johnson												
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO		17. INFORMANT				ADDRESS		
yes Korea				216-24-7486		Mrs. M. Elizabeth Johnson				1030 Marlow Dr. 12		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute Alcoholic Intoxication												
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?				
19c. MEDICAL CERTIFICATION								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No				City or Town	County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>Werner U. Spitz, M.D.</i>				M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type)								ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				
								DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
								ADDRESS (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City or Town)		(County)	(State)	
Burial				10/29/68		Baltimore Nat'l. Cem.		Baltimore		Md.		
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Mitchell-Wiedefeld Home-6500 York Rd-21212								NOV 1 1968		<i>Charles Judge</i>		



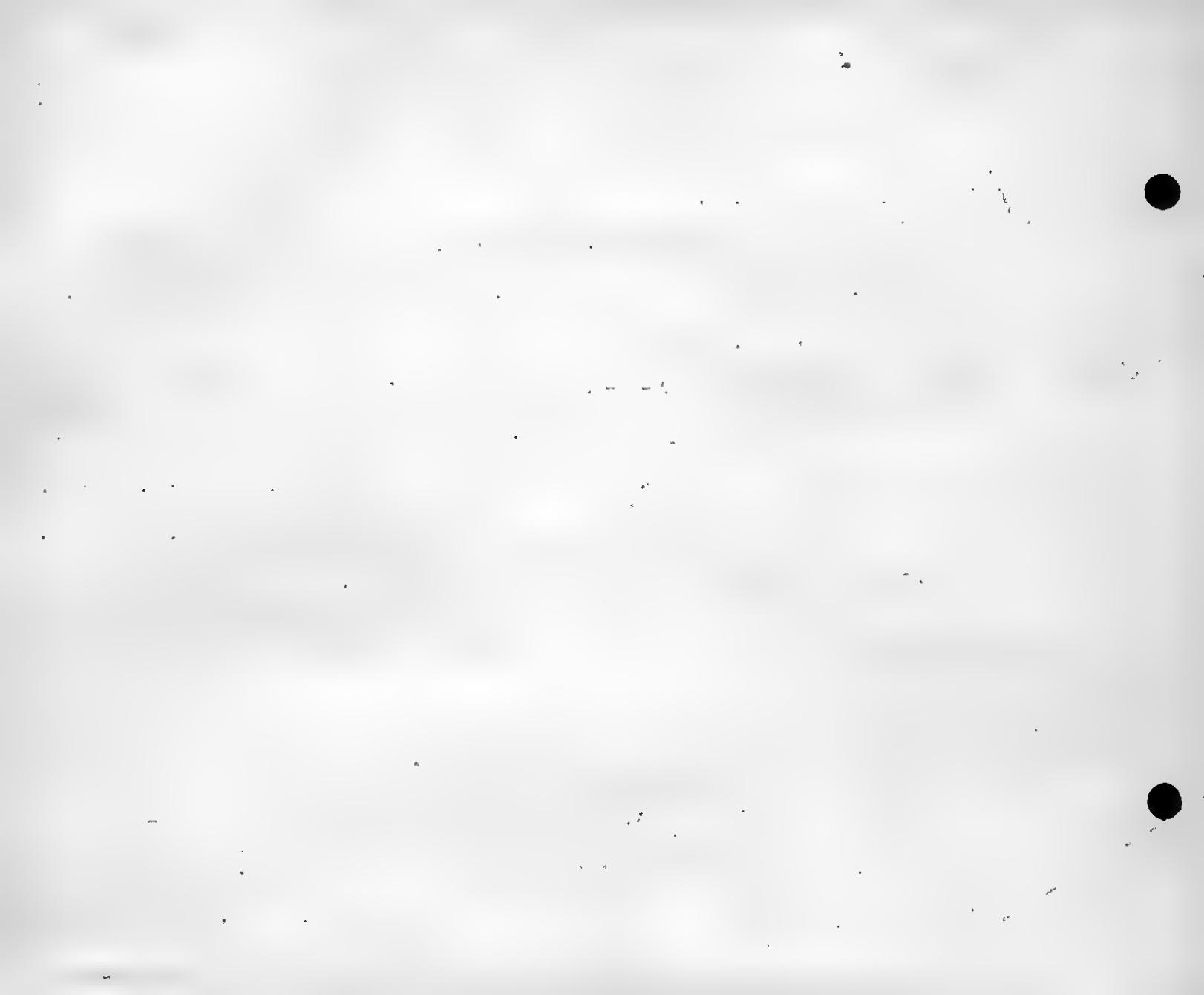
CERTIFICATE OF DEATH

14053

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Watt	Middle Tyler	Last Johnson	20. DATE OF DEATH Month October	Day 25,	Year 1968	20. HOUR a.m.
3. SEX male	4 RACE Negro	S. DATE OF BIRTH April 16, 1910	6. AGE (in years last birthday) 58 yrs.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	HOURS	MIN.
7a BIRTHPLACE (State or foreign country) Virginia	7b CITIZEN OF WHAT COUNTRY? U. S.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH Baltimore				
10 CITY OR TOWN OF DEATH Catonsville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Laborer	12b. KIND OF BUSINESS OR INDUSTRY fertilizer			
13a. US/JAL RESIDENCE (Where deceased lived, if institutional: Residence before admission) STATE Md.	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 2838 West Mulberry St.	plant			
14 FATHER'S NAME Charles C. Johnson	15. MOTHER'S MAIDEN NAME Rose			Middle	Lost		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown 33726274	16b. SOCIAL SECURITY NO. 1945 Army	17 INFORMANT Records: SPRING GROVE STATE HOSPITAL	Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction, acute, death</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate							
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic, Cardiovascular Ht. Dis. 5 yrs.</u>							
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis, Generalized, Senile. 5 yrs.</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Pulmonary Emphysema and chronic Bronchitis.</u>							
19a. MEDICAL CERTIFICATION DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from Dec. 15, 1966, to Oct. 25, 1968, that (I) <input type="checkbox"/> (we) last saw the deceased alive on Oct. 25, 1968, and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.							
22b. SIGNATURE <i>Anthony J. Young, M.D.</i>	DEGREE PHYS.	ATTENDING PHYS.	MED DIRECTOR	STAFF PHYS.	22c. DATE SIGNED 10-25-68		
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10-31-68	23c. NAME OF CEMETERY OR CREMATORIAL Church Cem.	23d. LOCATION (City or Town) Westmoreland Co. PA		(County)	(State)	
24. FUNERAL DIRECTOR V.R. Bailey	ADDRESS Kelson Funeral Home 1348 N. Calhoun St.	25a. RECD BY REGISTRAR DACT 29 1968	25b. REGISTRAR'S SIGNATURE <i>Charles J. Young</i>				



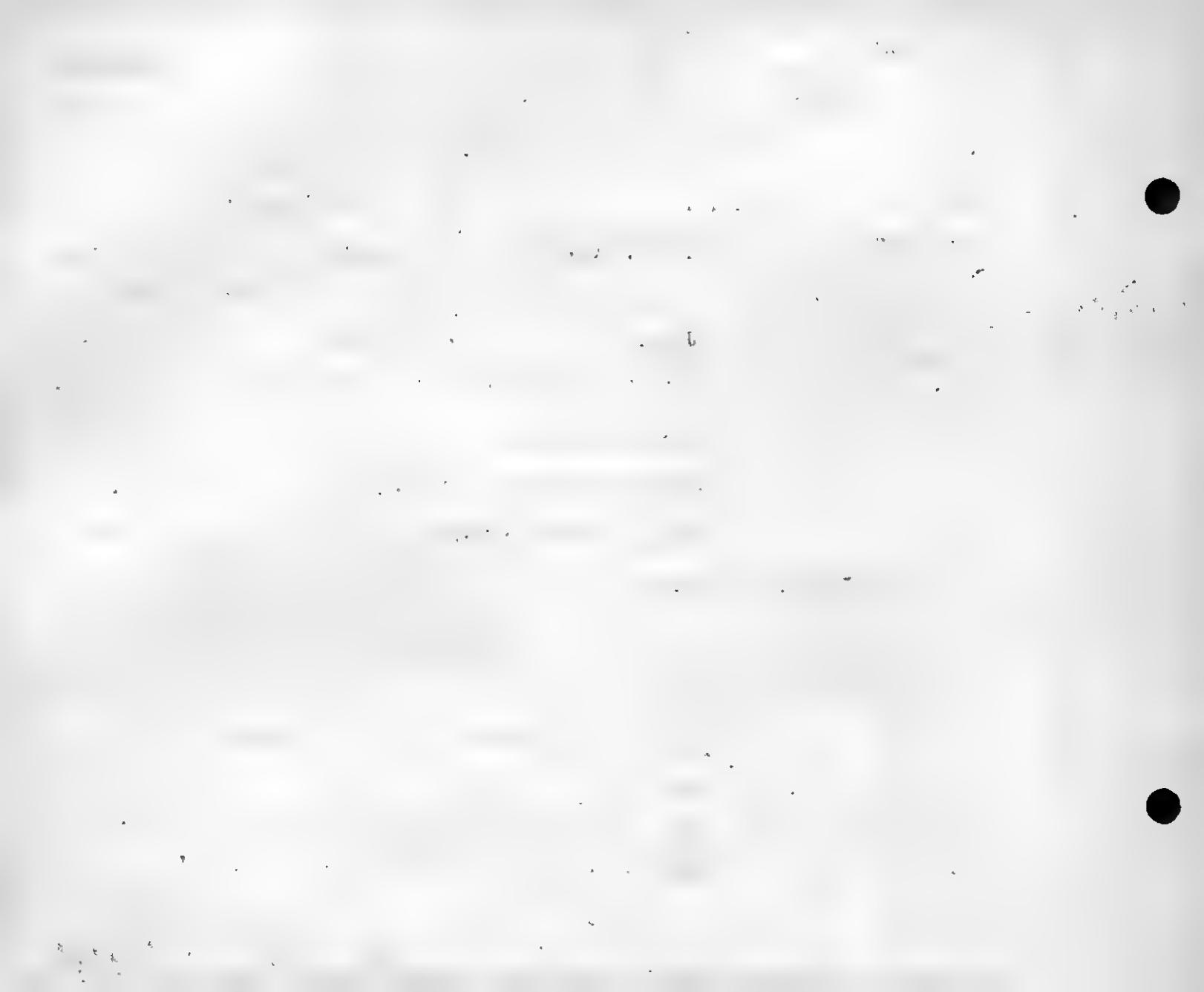
**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**
CERTIFICATE OF DEATH

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

I. DECEASED-NAME (Type or print)		First MACON		Middle	Lost JONES	2d DATE OF DEATH Month 10 Year 68	2d. HOUR 6:00PM	
3. SEX MALE		4. RACE NEGRO		5. DATE OF BIRTH 6/3/96		6. AGE (In years last birthday) 72 yrs.		
7a. BIRTHPLACE (State or foreign country) NORTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE COUNTY		
10. CITY OR TOWN OF DEATH FORT HOWARD		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VET. ADM. HOSPITAL		12a. US. A. OCCUPAT. ON (Kind of work done during most of working life, even if retired) LABORER		12b. KIND OF BUSINESS OR INDUSTRY STEEL CO.		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Res. before admission) STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INS. DE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 616 Warner Street	
14. FATHER'S NAME JOHN		Middle JONES	Lost	15. MOTHER'S MAIDEN NAME LENORA		Middle	Lost THOMPSON	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES		16b. SOCIAL SECURITY NO. WH 1		17. INFORMANT CLIN. RECORDS, VA HOSPITAL FT HOWARD, MD.		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		BRONCHOPNEUMONIA						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH RECENT
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 4		DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE						OLD
		DUE TO, OR AS A CONSEQUENCE OF (c) ADENOMA, PITUITARY GLAND						OLD
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) BENIGN PROSTATIC HYPERTROPHY, OLD								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/> YES		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10/1/68, 19, to 10/7/68, 19, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10/7/68, 19, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (not) view the body after death.								
22b. SIGNATURE <i>Erhard J. Bunyan</i>		DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED 10/8/68		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS VAH FORT HOWARD, MARYLAND						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 10/11/68		23c. NAME OF CEMETERY OR CREMATORIAL BALTIMORE NATIONAL		23d. LOCATION (City or Town) BALTIMORE, MARYLAND		
24. FUNERAL DIRECTOR <i>Charles a Rice</i>		ADDRESS CHARLES A RICE FUNERAL HOME 661 W. Barre St. Baltimore, Md.		25a. RECD. BY REGISTRAR 9 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14055

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician one completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month	Year	2b. HOUR A 12:20M			
			PAUL	NEWTON	JONES	OCTOBER	28, 1968				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS		
MALE		WHITE		AUGUST 23, 1896		72 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 COUNTY OF DEATH					
PENNSYLVANIA		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		BALTIMORE					
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
TOWSON			ST. JOSEPH HOSPITAL			SELF-EMPLOYED			GAS STATION		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
MARYLAND		BALTIMORE						5922 CLAYTON AVE. #21206			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
			Robert	Newton	Jones	Marie					Mowry
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown			16b. SOCIAL SECURITY NO (To give war or dates of service)			17. INFORMANT			Address		
No			204-16-2048A			Mrs Elizabeth Jones			5922 Clayton Ave. 6		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>											
DUE TO, OR AS A CONSEQUENCE OF <u>thrombosis of the left anterior descending coronary artery</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause											
(b) <u>coronary arteriosclerosis</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u>coronary arteriosclerosis</u>											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
4201		19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No			City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>October 27, 1968</u> , to <u>October 28, 1968</u> , that (I) (we) last saw the deceased alive on <u>October 28, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Lawrence J. Misanik</u>											
DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22c. DATE SIGNED <u>10-28-68</u>											
22d. PHYSICIAN'S NAME (Type)		Lawrence J. Misanik, M.D.			22e. ADDRESS						
					7620 York Road, Towson, Md. 21204						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION (City or Town)		(County)	(State)	
Burial		10-31-1968		Gardens of Faith Cemetery			Baltimore		Co.	Md	
24. FUNERAL DIRECTOR		ADDRESS						25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE		
		Lassahn Funeral Home 7401 Belair Road 21236						OCT 30 1968	<u>Charles Judge</u>		
VR A15 30M REV.								DATE			



~~1~~ TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

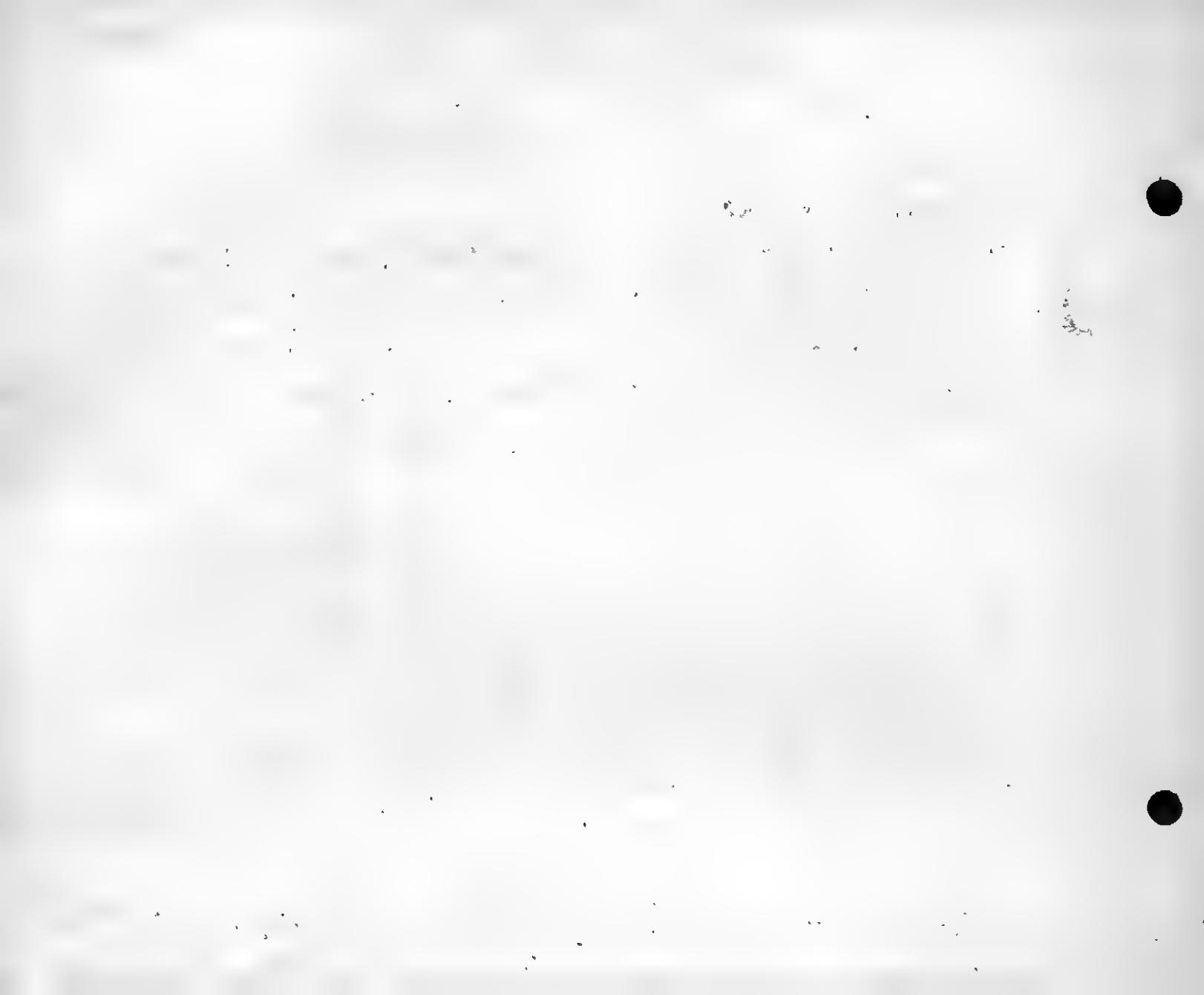
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Items 5 & 6 Film Ch 06
10/31/68 kk MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14056

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)	First <u>SARA</u>	Middle <u>Edith</u>	Last <u>Jones</u>	2a. DATE OF DEATH Month 10	2b. HOUR Year 1968
25	5 A.M.				
3. SEX <u>Female</u>	4. RACE <u>White</u>	S. DATE OF BIRTH 22, 1890 Aug. 15/1960	6. AGE (In years last birthday) 78 yrs	IF UNDER 1 YEAR MONTHS GAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <u>BALTIMORE</u>		
10. CITY OR TOWN OF DEATH <u>Towson, Md.</u>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Aged Men + Womens Home Registered Nurse</u>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Housewife</u>	12b. KIND OF BUSINESS OR INDUSTRY <u>501 Sheridan Ave.</u>		
13a. U.S. AL RESIDENCE (Where deceased lived, if institution admission) STATE <u>Md.</u>	13c. CITY OR TOWN <u>Balto.</u>	13d. INSIDE CITY UNIT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <u>615 Chestnut Ave.</u>		
14. FATHER'S NAME First <u>Edward</u>	Middle <u>Jones</u>	15. MOTHER'S MAIDEN NAME First Middle <u>Mary Kane</u>	Last <u>Jones.</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <u>Unknown</u>	16b. SOCIAL SECURITY NO <u>214-144-035</u>	17. INFORMANT <u>Daisy E. Hamilton, 615 Chestnut Ave.</u>	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>HSCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>					
2-3 years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from August 15, 1968, to October 25, 1968, that (I) (we) last saw the deceased alive on October 25, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Merleland E. Day MD</u>					
22c. DATE SIGNED <u>October 25, 1968</u>					
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS <u>4-8-33rd St Baltimore Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>10-28-68</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>London Park</u>	23d. LOCATION (City or Town) <u>Baltimore</u>	(County) <u>M D</u>	(State)
24. FUNERAL DIRECTOR ADDRESS <u>Wm Cook - Brooks Towson Towson MD</u>	25a. REC'D BY REGISTRAR DATE OCT 29 1968				
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

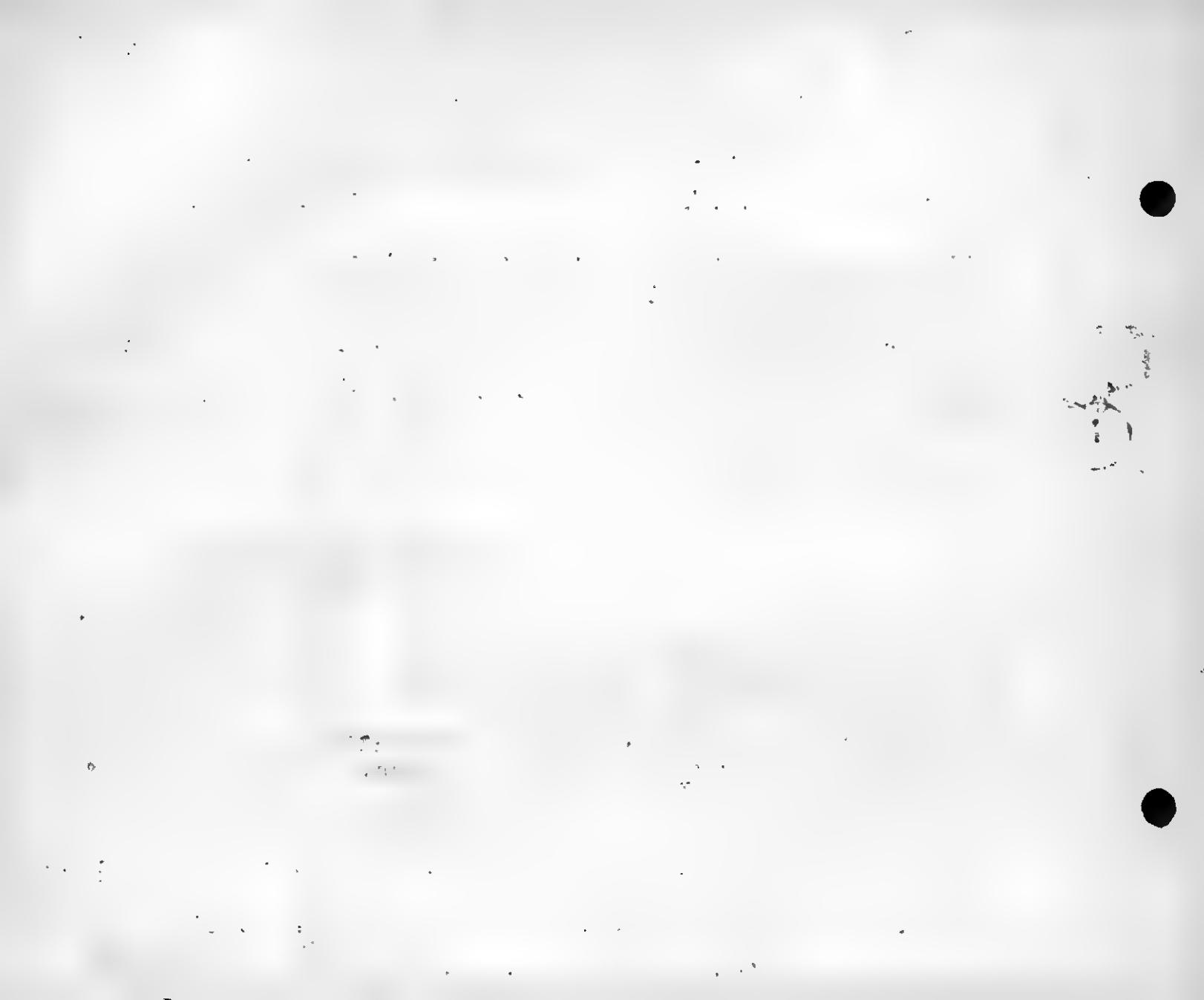
CERTIFICATE OF DEATH

14057

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Part 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First Ida	Middle Natalie	Last Jorcyk	2a. DATE OF DEATH 10 Month 13 Day 68 Year	2b. HOUR 7:15	
3 SEX Female	4 RACE White	5. DATE OF BIRTH May 8, 1894		6 AGE (In years last birthday) 74 yrs	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Penns	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore County			
10. CITY OR TOWN OF DEATH Towson	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Great. Balt. Med. Cen.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Perry Hall	13d. INSIDE CITY: IN TSZ YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 9104 Deborah Ave		
14. FATHER'S NAME Albert	Middle Swaihuber	Last Swaihuber	15. MOTHER'S MAIDEN NAME Minnie	Middle Malina	Last Malina	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No	16b. SOCIAL SECURITY NO.	17. INFORMANT Mrs Helen Koch	Address Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Emboli 20ix Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause DUE TO, OR AS A CONSEQUENCE OF Hodgkins Disease (b) DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____			
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from Sept. 14, 1968 to Oct. 13, 1968, that <input type="checkbox"/> (we) lost saw the deceased alive on Oct. 13, 1968, and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) (did) (do not) view the body after death.						
22b. SIGNATURE <i>Hernia n/a</i>		DEGREE ATTENDING PHYS.	<input type="checkbox"/> MED DIRECTOR	<input checked="" type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED Oct. 13, 1968	
22d. PHYSICIAN'S NAME (Type) Abdolvahab Purnia		22e. ADDRESS Greater Baltimore Medical Center				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/16/68	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Evergreen	23d. LOCATION (City or Town) (County) (State) Bell Mountain Penna		
24. FUNERAL DIRECTOR Leonard J Ruck Inc.		ADDRESS Baltimore, Md		OCT 14 1968	25. REGISTRAR'S SIGNATURE Charles George	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14058

14047

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, page 4 may be retained by the hospital or attending physician.
 director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)			First <i>MARIE</i>	Middle <i>W. Jordan</i>	Last Lost	2a. DATE OF DEATH Month <i>OCT.</i> Day <i>9</i> , Year <i>1968</i>	2b. HOUR <i>108 M</i>
3. SEX Female		4 RACE White	5 DATE OF BIRTH Sept. 7, 1876.		6. AGE (in years last birthday) <i>92</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>Germany</i>		7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Baltimore, Md.</i>		
10. CITY OR TOWN OF DEATH <i>Parkton</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Rt. 1, Armacost Road</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Baltimore</i>	13c. CITY OR TOWN <i>Parkton</i>	13d. INSIDE CITY LIMIT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER <i>Rt. 1, Armacost Road</i>		
14. FATHER'S NAME First <i>Frederick</i>			Middle <i>T.</i>	Last <i>Gotsch</i>	15. MOTHER'S MAIDEN NAME First ? Middle <i>Gehring</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <i>Mrs. Bertha J. Mays</i>		Address <i>(Same)</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>A.S.C.V. disease</i> 4ia / DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). (b) _____ stating the <u>underlying cause</u> last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>1960</i> , to <i>Oct. 9, 1968</i> , that (I) (we) last saw the deceased alive on <i>10/9/68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>A. M. France</i>		22c. DEGREE <i>MD</i>	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22d. DATE SIGNED <i>10/19/68</i>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <i>PARKTON MD.</i>					
23a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>10/14/68.</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Parkwood Cemetery</i>		23d. LOCATION (City or Town) <i>Baltimore, Md.</i>	(County) <i>Baltimore, Md.</i>	(State) <i>Md.</i>
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Baltimore, Md. 21214		ADDRESS		25a. RECEIVED BY REGISTRAR <i>OCT 11 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	DATE	



FOR STATE
HEALTH DEPT.

Any delay is
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item 3. Page
5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Department of
Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. DECEASED-NAME 10043 Clarence			First	Middle	Last	2a. DATE KNOWNED 10/8/68	Month	Day	Year	2b. HOUR 14050			
3. SEX male	4. RACE white	5. DATE OF BIRTH 6-2-1883	6. AGE (In years last birthday) 85	7. UNDER 1 YEAR MONTHS YRS	8. IF UNDER 24 HRS MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD Month October	Day	Year	2d. HOUR 1968				
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore	10. CITY OR TOWN OF DEATH Towson				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph's Hosp.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) self employed	12b. KIND OF BUSINESS OR INDUSTRY Fish Market
13a. US.J.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN 21234	13d. INSIDE CITY LIMITS? YES	13e. STREET AND NUMBER 6635 Wycombe Way							
14. FATHER'S NAME David Joynes			15. MOTHER'S M AIDEN NAME Susan Livingston										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 218329583		17. INFORMANT Mrs Minnie E. Joynes		ADDRESS same							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Encephalomalacia of Pons. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 Days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause 1341 Generalized Arteriosclerosis 10 yr. lost. (b) (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 332-X													
19a. MEDICAL CERTIFICATION DATE OF OPERATION 19/6			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? Family Permitted YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH WHILE AT WORK		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) Autopsy									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State										
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> Charles F. O'Donnell, M.D.													
ACTUAL SIGNATURE Charles F. O'Donnell, M.D.		CHIEF MEDICAL EXAMINER MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 10/3/68				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)		ADDRESS (Street, city, town, or county) Baltimore Cemetery											
23a. BURIAL, CREMATION, REMOVAL, (Specify) Burial		23b. DATE 10/7/68		23c. NAME OF CEMETERY OR CREMATORIAL Baltimore Cemetery		23d. LOCATION (City or Town) Baltimore, Md.		(County)		(State)			
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc Baltimore, Md.		ADDRESS		25a. REC'D. BY REGISTRAR DATE OCT 4 1968		25b. REC'D. BY SURNATANT DATE Charles Judge							
VR 15ME (5) 1DM REV 1/68													



Item 6 Film G4 6 11/7/68 kk MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
14049

CERTIFICATE OF DEATH

14060

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be retained by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of the death.

1	I. DECEASED NAME (Type or print)	First JOHN F. KALB	Middle	Last	2a. DATE OF DEATH Month 10 Day 68 Year	2b. HOUR 8:55 AM
3	SEX m	4. RACE w	S. DATE OF BIRTH 12/14/69	6. AGE (In years less birthday) 99/8 yrs.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS
7a	BIRTHPLACE (State or foreign country) Md	7b. CITIZEN OF WHAT COUNTRY? U.S.	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH BALTIMORE	Md.	
10	CITY OR TOWN OF DEATH CATONSVILLE	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HAROLD PARK	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) CARPENTER	12b. KIND OF BUSINESS OR INDUSTRY M.C.I.		
13a	USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md	13c CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Reed & Bellinger Rd		
14	FATHER'S NAME DAVID KALB	First	Middle	Last	15. MOTHER'S MAIDEN NAME First ELIZABETH LOR	Middle
16a	WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no	16b SOCIAL SECURITY NO	17. INFORMANT EDGAR A. KALB	Address	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years	
18	CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Cardio-vascular Disease 412.9 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7121						
19a. MEDICAL CERTIFICATION	DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a	ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	2 b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
2 d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	2 e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC)	21f LOCATION Street or R.F.D. No	City or Town	County	State	
22o. I certify that (I) (b) (b) attended the deceased from June 19 58, to Oct. 19 68, that (I) (b) last saw the deceased alive on October 28 19 68, and that in (my) (a) opinion death occurred on the date and hour and from the causes stated above, (I) (b) (d) (dd) not view the body after death						
22b. SIGNATURE	Leo J. Gaver, M.D.		DEGREE ATTENDING PHYS	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 10/30/68
22d. PHYSICIAN'S NAME (Type)			22e ADDRESS 1 Mallow Hill Ave., Baltimore, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 11/2/68	23c. NAME OF CEMETERY OR CREMATORIAL Lorraine	23d. LOCATION (City or Town) BALTIMORE, MD.	(County)	(State)	
24. FUNERAL DIRECTOR F. S. MACNARB	ADDRESS 301 FREDERICK 21728	25a. RECEIVED BY REGISTRAR NOV 4 1968	25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

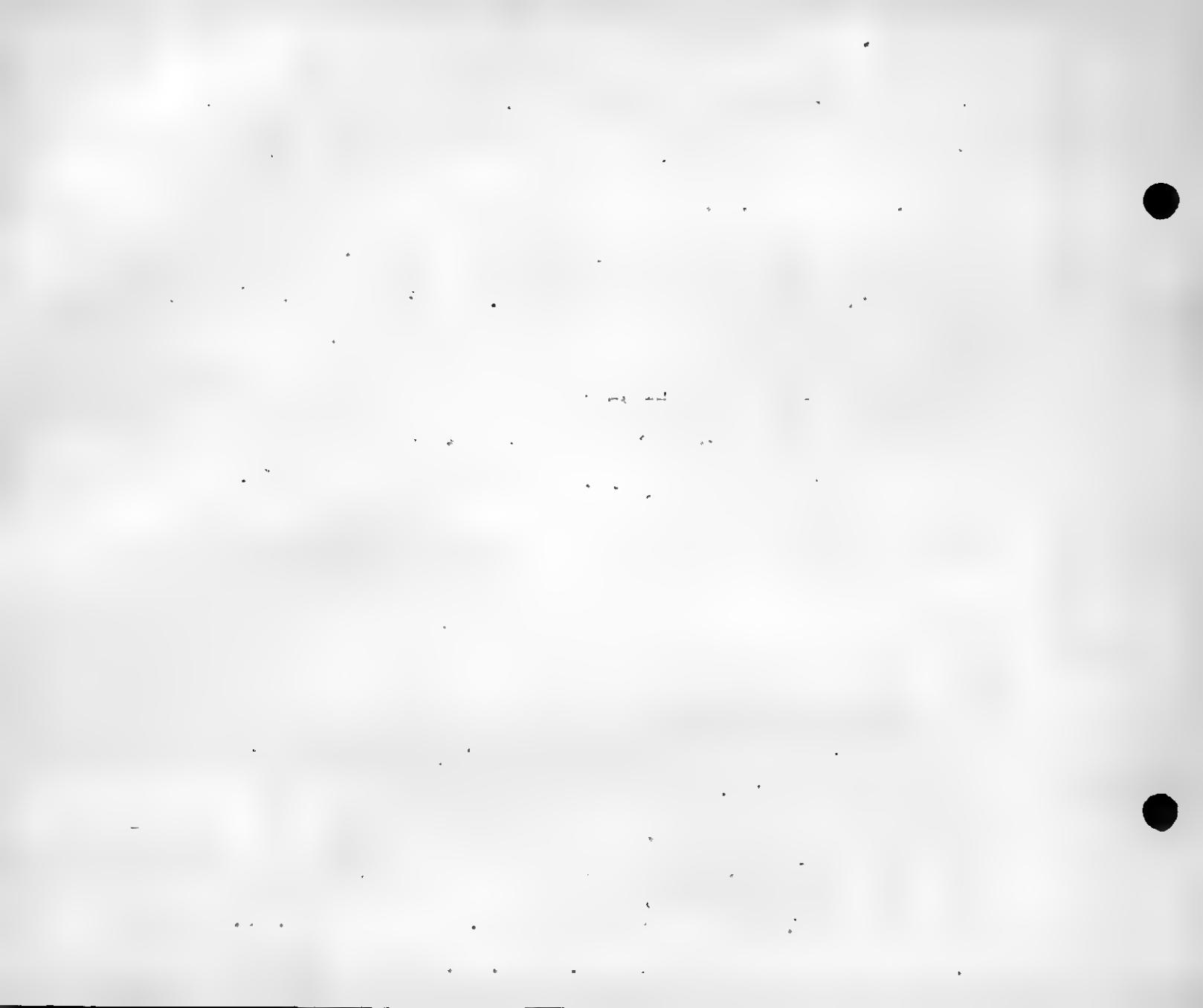
16050

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14061

1. DECEASED NAME (Type or print)	First Bert	Middle L. Kattenhorn	Last	2a. DATE OF DEATH Month October	2b. HOUR Day 28, 1968 1:45 p.m.
3. SEX male	4. RACE white	S. DATE OF BIRTH Nov. 18, 1897	6. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? U. S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore		
10. CITY OR TOWN OF DEATH Catonsville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) laborer	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.	13b. COUNTY	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 3437 Old Frederick Rd.	
14. FATHER'S NAME First ?	Middle	Last	15. MOTHER'S MAIDEN NAME First ?	Middle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Army	16b. SOCIAL SECURITY NO 1917-19	17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Benign organic calcification Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) O liver metastasis DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1621					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
MEDICAL CERTIFICATIONS					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At Home, Farm, Street, Factory, Office Building, Etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Jan. 1, 1968 , to Oct. 28, 1968 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Oct. 28, 1968 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (did not) view the body after death.					
22b. SIGNATURE Rafael H. Marin, M.D.	DEGREE ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 10-28-68	
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Oct. 30, 1968	23c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cem.	23d. LOCATION (City or Town) Balto. Md.	(County)	(State)
24. FUNERAL DIRECTOR G. Truman Schwab 3512 Frederick Ave. Balto. Md.	ADDRESS		25a. REC'D BY REGISTRAR DATE OCT 31 1968	25b. REGISTRAR'S SIGNATURE Charles Judge	
VR A15 30M REV 6/68					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

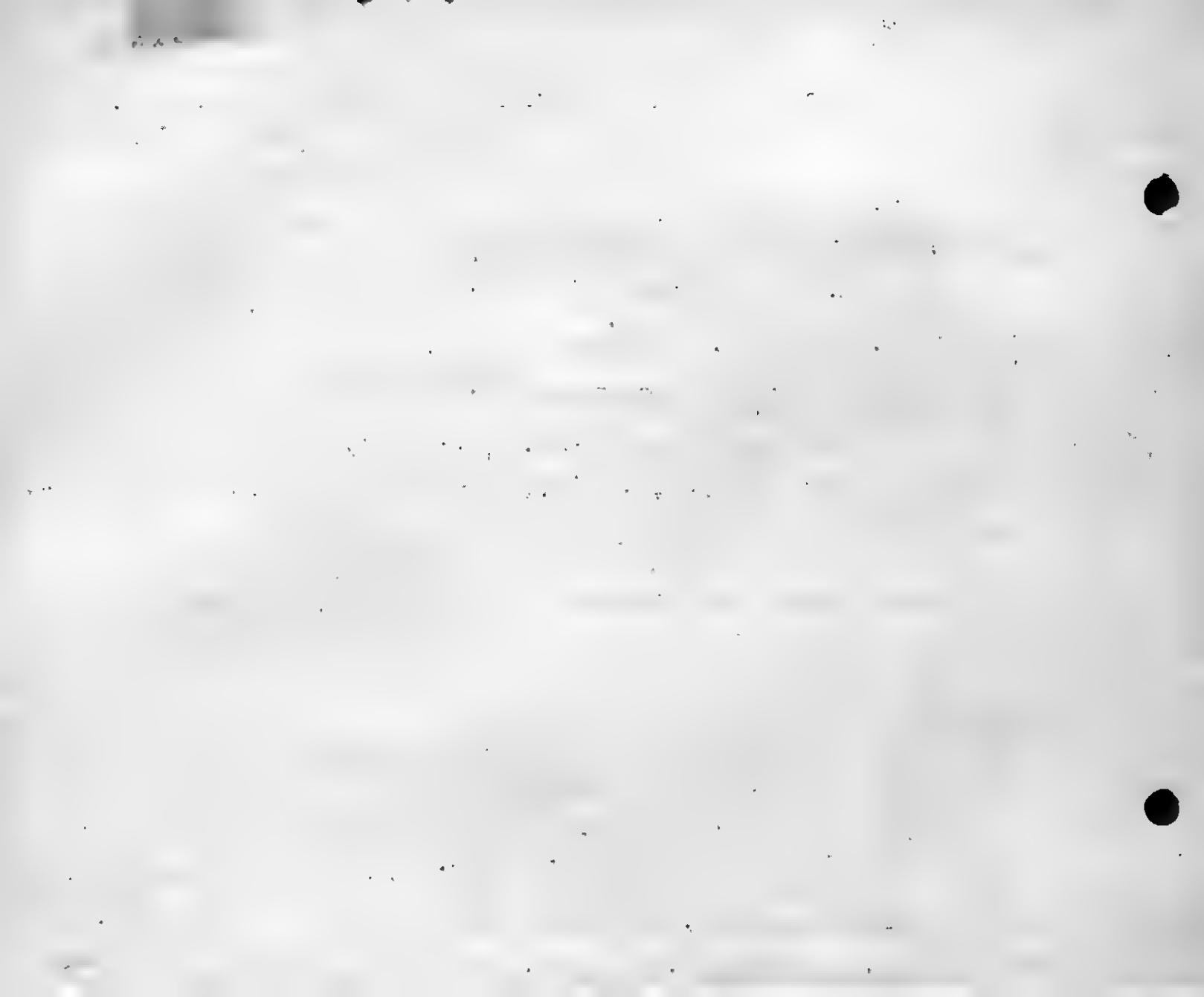
14051

14062

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, please remove carbon papers pages 1 and 2. Then please remove carbon papers pages 3 and 4, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First HARRY	Middle L.	Last KELLUM	2a. DATE OF DEATH October 30 , 19 68	2b. HOUR 6:30 P.M.
3. SEX Male	4 RACE White	5. DATE OF BIRTH June 10, 1889.			6. AGE (In years lost birthday) 79 yrs.	IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN. 0
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore	Baltimore Md
10. CITY OR TOWN OF DEATH Catonsville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) House in the Pines 16 Fusting Ave.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Clerk-Dept. Education		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.	13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMIT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 7041 Eastbrook Avenue	12b. KIND OF BUSINESS OR INDUSTRY	
14. FATHER'S NAME First John	Middle J.	Last Kellum	15. MOTHER'S MAIDEN NAME First Mary	Middle Griffo	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or Unknown No	16b. SOCIAL SECURITY NO (If yes give war or dates of service) 213-1U-6933	17. INFORMANT Mrs. Rosalyn McGrane	Address Same,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Decompensation 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause { last (b) Atherosclerotic Cardio-Vascular Disease. DUE TO, OR AS A CONSEQUENCE OF (c)						
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs.						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4271						
19a. DATE OF OPERATION 4/27/68	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (This hospital) attended the deceased from 7-22-68 to 10-30-68 , that (I) (We) last saw the deceased alive on 10-28-68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (They) (did not) view the body after death.						
22b. SIGNATURE Wilmer K. Gallagher, M.D.	DEGREE M.D.	ATTENDING PHYS M.D.	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 10-31-68	
22d. PHYSICIAN'S NAME (Type) Wilmer K. Gallagher, M.D.	22e. ADDRESS 6209 Frederick Ave. Baltimore, Md. 21228					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11/2/68.	23c. NAME OF CEMETERY OR CREMATORIUM New Cathedral Cemetery	23d. LOCATION (City or Town) Baltimore, Md.	(County) Baltimore	(State) Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Baltw. Md. 21214	ADDRESS Leonard J. Ruck, Inc. Baltw. Md. 21214	25a. REC'D. BY REGISTRAR NOV 4 1968	25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

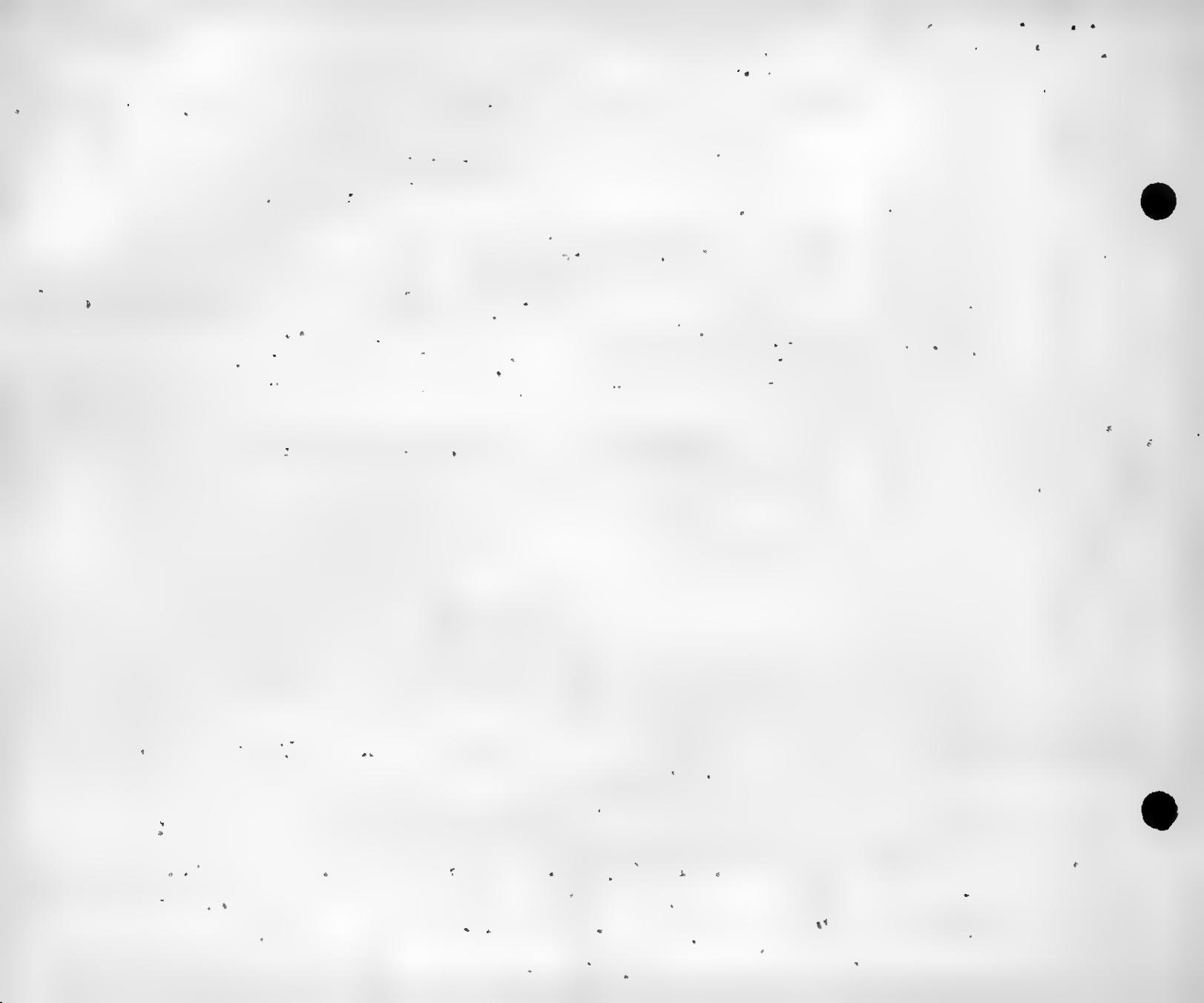
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14063

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)	First Damian	Middle Winfield	Last Kessler	20. DATE OF DEATH Month 10	Day 26	Year 1968	2b. HOUR 12 ³⁰ P.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH June 17, 1962			6. AGE (in years lost birthday) 6 yrs.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Baltimore,				
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMIT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 2820 Westfield Ave., 21214			
14. FATHER'S NAME Chas. W. Kessler	First Chas.	Middle W.	Last Kessler	15. MOTHER'S, MAIDEN NAME Ely Slaughter	First Ely	Middle Slaughter	Last Samuel
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes, no, or unknown	16b. SOCIAL SECURITY NO. —	17. INFORMANT 320.8	Address Mother Samuel				
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Meningitis due to achromobacter (Mino-Herella)							
DUE TO, OR AS A CONSEQUENCE OF (b) _____							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____							
DUE TO, OR AS A CONSEQUENCE OF (d) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from 10/25/1968 , to 10/26/1968 , that <input type="checkbox"/> (we) last saw the deceased alive on 10/26/1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Lawrence F. Misanik, M.D.							
22c. DATE SIGNED 10/26/68							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 7620 York Rd., Towson, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 10/19/68	23c. NAME OF CEMETERY OR CREMATORIUM Oaklawn			23d. LOCATION (City or Town) Baltimore Co. (County) (State)	
24. FUNERAL DIRECTOR John Neumann 6067 Harford Rd.		ADDRESS			25a. REC'D BY REGISTRAR DATE NOV 1 1968		25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

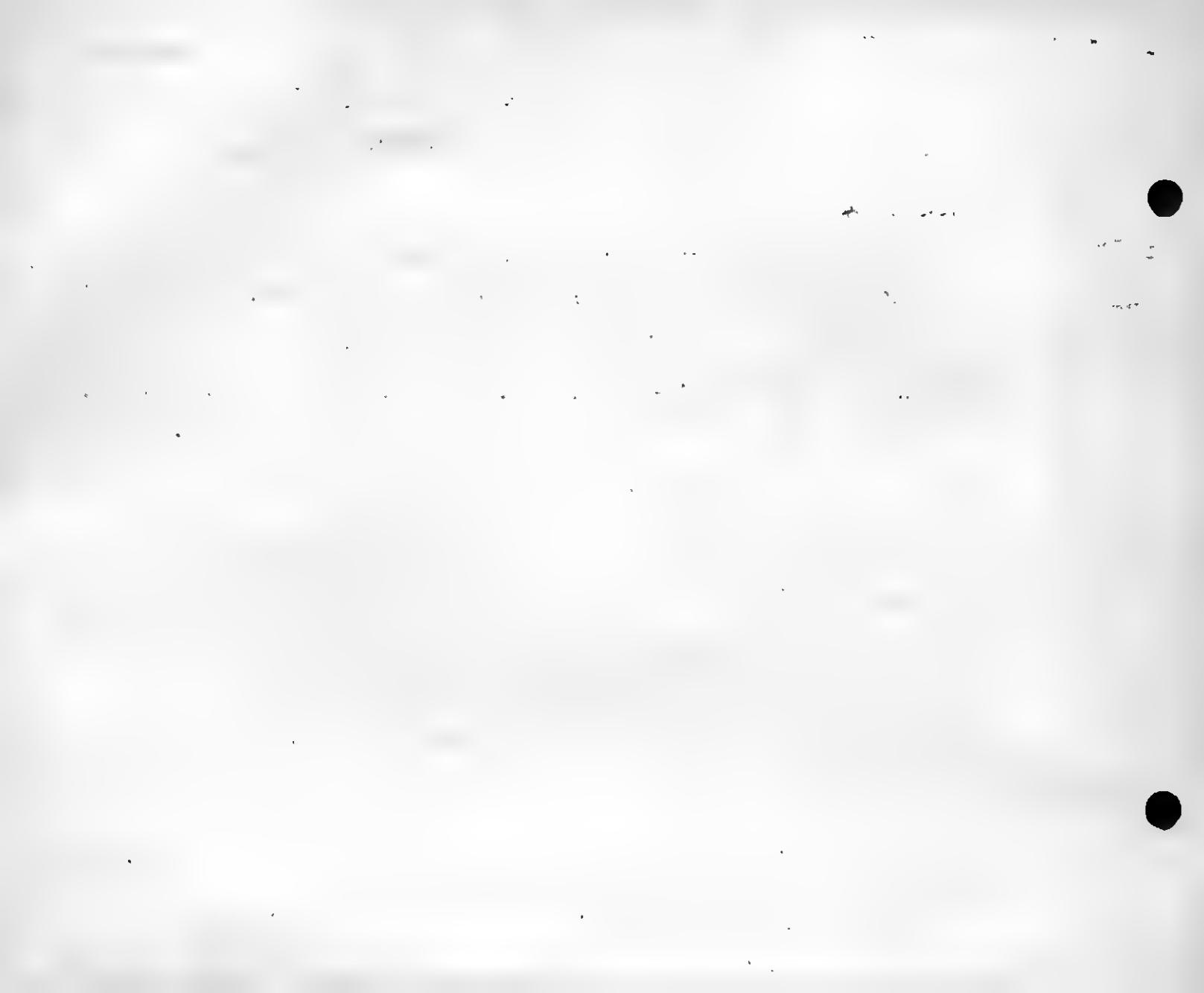
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14064

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, he funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)	First <i>Belle</i>	Middle <i>King</i>	Last <i>[Redacted]</i>	2a. DATE OF DEATH Oct. Month 6 Day 68 Year <i>6/6/68</i>	2b. HOUR <i>9:00 A.M.</i>		
3. SEX <i>FEMALE</i>	4. RACE <i>WHITE</i>	5. DATE OF BIRTH <i>[Redacted]</i>		6. AGE (in years last birthday) <i>72</i>	IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS. HOURS <i>0</i>	MIN. <i>0</i>
7a. BIRTHPLACE (State or foreign country) <i>Russia</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>BALTIMORE</i>				
10. CITY OR TOWN OF DEATH <i>Baltimore Co.</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>MILFORD MANOR NURSING HOME</i>		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) <i>HOUSEWIFE</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>MARYLAND</i>	13b. COUNTY <i>—</i>	13c. CITY OR TOWN <i>BALTIMORE</i>	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>2833 W. COLD SPRING LANE</i>			
14. FATHER'S NAME First <i>SAMUEL</i>	Middle <i>TUROW</i>	15. MOTHER'S MAIDEN NAME First <i>HASSAH</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>NO</i>	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <i>217-01-07121</i>	17. INFORMANT <i>MRS. CHARLOTTE KAUFMAN, 5701 STUART AVE. #2121</i>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>41</i>				acute myocardial infarction			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>hypertension + arteriosclerotic cardiovascular disease</i>							<i>years</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>hypertension + arteriosclerotic cardiovascular disease</i>							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>left hemiplegia</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>1958</i> , to <i>10/6/68</i> , that (I) (we) last saw the deceased alive on <i>10/5/68</i> , and that in (my) (<i>our</i>) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Louis R. Maser M.D.</i>		DEGREE <i>[Signature]</i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>2/2/69</i>	
22d. PHYSICIAN'S NAME (Type) <i>Louis R. Maser M.D.</i>		22e. ADDRESS <i>2724 SMITH AVE BALTIMORE MD 21209</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>10-9-68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>OHEL YAKOV</i>		23d. LOCATION (City or Town) <i>BALTIMORE, MARYLAND</i>	(County) <i>BALTIMORE</i>	(State) <i>MARYLAND</i>
24. FUNERAL DIRECTOR <i>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</i>		ADDRESS <i>[Signature]</i>		25a. REC'D BY REGISTRAR <i>OCT 9 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 DECEASED NAME (Type or print)		First MARIE	Middle D.	Last KIRCHENBAUER	2a. DATE OF DEATH Month OCTOBER	Day 22, 1968	Year 1968	2b. HOUR 2:20 P.M.			
3 SEX FEMALE		4. RACE WHITE		S. DATE OF BIRTH MAY 31, 1911	6 AGE (In years last birthday) 57 YRS.		F UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	HOURS HOURS	MIN MIN	
7a. BIRTHPLACE (State or foreign country) NEW JERSEY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE,						
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Sales Lady		12b. KIND OF BUSINESS OR INDUSTRY DEPT. STORE					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) MARYLAND		13b. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 8425 E OLD HARFORD RD. #34					
14. FATHER'S NAME First DonDero		Middle 	Last 	IS MOTHER'S MAIDEN NAME First Clara		Middle 	Last Dougherty				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 215-07-0773		17 INFORMANT Mr Forrest S Kirchenbauer		Address Same				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardiac tamponade DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) rupture of myocardium sec. to acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) thrombosis rt. coronary artery											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 19, 1968, to October 22, 1968, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 22, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Ines Cilliani</i>		DEGREE PHYS.	ATTENDING PHYS.	<input type="checkbox"/>	MED. DIRECTOR	<input type="checkbox"/>	STAFF PHYS.	<input type="checkbox"/>	22c. DATE SIGNED OCT 23 1968		
22d. PHYSICIAN'S NAME (Type)		Ines Cilliani, M.D.		22e. ADDRESS 7620 York Rd. k Towson, Md. 21204							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/24/68		23c. NAME OF CEMETERY OR CREMATORIAL Parkwood		23d. LOCATION (City or Town) Baltimore, Maryland		(County)	(State)		
24. FUNERAL DIRECTOR		ADDRESS Leonard J Ruck Inc. Baltimore, Maryland		25a. REC'D BY REGISTRAR OCT 23 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by me, and 2 director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Prior to removal, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16 14055

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14066
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)	First <i>WALTER</i>	Middle <i>E.</i>	Last <i>KNAPP</i>	2a. DATE OF DEATH 10 Month 16 Day 68 Year	2b. HOUR 8:15 P.M.
3. SEX <i>M</i>	4. RACE <i>W</i>	S. DATE OF BIRTH <i>5/30/1884</i>	6. AGE (In years lost birthday) <i>84 yrs.</i>	IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>PENNA.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>BALTO.</i>		
10. CITY OR TOWN OF DEATH <i>CATONSVILLE</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Shady Neck Home</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Railroad</i>			12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Md</i>	13b. COUNTY <i>BALTO</i>	13c. CITY OR TOWN <i>CATONSVILLE</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>310 Thackery Ave.</i>	
14. FATHER'S NAME First <i>John</i>	Middle <i>T.</i>	Last <i>KNAPP</i>	15. MOTHER'S MAIDEN NAME First Middle Last <i>? Knobly</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO <i>—</i>	17. INFORMANT <i>MRS. Ruby KNAPP</i>	Address <i>310 Thackery Ave.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Anterior sclerotic condensative disease</i> / 10 yrs + DUE TO, OR AS A CONSEQUENCE OF <i>with chronic failure</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) /					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from Aug. 2, 1956, to Oct. 16 1968, that (I) (we) last saw the deceased alive on Aug. 16 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>John A. Nesbitt Jr., M.D.</i>		DEGREE ATTENDING PHYS	MED DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 10-17-68
22d. PHYSICIAN'S NAME (Type) <i>John A. Nesbitt, Jr., M.D.</i>		22e. ADDRESS <i>1009 Frederick Road</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>10/19/68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>LORRAINE CEM.</i>		23d. LOCATION (City or Town) <i>BALTO.</i>
24. FUNERAL DIRECTOR <i>E.S. MacNabb</i>		ADDRESS <i>301 Frederick Rd Balto. 28-174</i>	25a. REC'D BY REGISTRAR <i>Oct 21 1968</i>		25b. REGISTRAR'S SIGNATURE <i>John A. Nesbitt Jr., M.D.</i>
VR A15 30M REV. 1/68					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14067

16056

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Please and I should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Owen	Middle C.	Last Knauff	2a. DATE OF DEATH Month 10	Day 29	Year 68	2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH July 21, 1904			6. AGE (In years lost birthday) 64 yrs	IF UNDER 24 HRS. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore				
10. CITY OR TOWN OF DEATH Parkville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1509 Clearwood Rd			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Chauffeur			12b. KIND OF BUSINESS OR INDUSTRY Brewery
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY, J.M.T.S? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 1509 Clearwood Rd				
14. FATHER'S NAME Francis	First Middle I.	Lost	15. MOTHER'S MAIDEN NAME Knauff	First Briget	Middle Bannagan	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes	16b. SOCIAL SECURITY NO 1919-1920	17. INFORMANT Mrs Anna B Knauff				Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 2041 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				Chronic Tymphoblast Tumouria			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 718 months
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION 204		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>68</u> , to <u>Oct 27</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Sept 29</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Bernard S. Karpers, Jr.</i>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED <u>Oct. 29, 1968</u>		
22d. PHYSICIAN'S NAME (Type) BERNARD S. KARPERS, JR.		22e. ADDRESS 514 Medical Arts Bldg.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/2/68.	23c. NAME OF CEMETERY OR CREMATORIAL Baltimore Cemetery			23d. LOCATION (City or Town) Baltimore,	(County) Md. (State)
24. FUNERAL DIRECTOR Leona rd J Ruck Inc Baltimore, Maryland				ADDRESS		25a. REC'D BY REGISTRAR NOV 1 1968	25b. PRACTICER'S SIGNATURE <i>James S. Judge</i>

20

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P.M.C. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16057 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14068

1 DECEASED NAME (Type or Print)		First KERMIT	Middle C.	Last KNIGHT	2a DATE KNOWN OF EST- DEATH MATED <input checked="" type="checkbox"/>	Month 10-20	Day 168	Year M	2b HOUR 2d HOUR 8:30 A.M.		
3 SEX Male	4. RACE Colored	5 DATE OF BIRTH 1-13-50	6 AGE (In years last birthday) 18 yrs.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	MONTHS 0	HOURS 0	M.N. 0	2c. DATE PRONOUNCED DEAD Month October	Day 20	Year 1968
7a BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? Maryland		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE			
10 CITY OR TOWN OF DEATH TOWSON		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Expressway Ruxton Road Overpass			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.	13b COUNTY Baltimore	13c CITY OR TOWN Baltimore	13d INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER 2817 W. North Avenue							
14 FATHER'S NAME Charles Knight	First	Middle	Last	15 MOTHER'S MAIDEN NAME Mildred Foster	First	Middle	Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17 INFORMANT Mildred Knight	ADDRESS 2817 W. North		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple severe injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 2194											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day Year HOUR A.M. 7:40 AM 10-20 1968		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) Driver in auto-fixed object collision							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Expressway		21f LOCATION Street or R.F.D. No. Ruxton Road Overpass		City or Town Baltimore		County Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Charles S. Springate		EXAMINER'S NAME (Type) Charles S. Springate, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED October 20, 1968		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-24-68		23c. NAME OF CEMETERY OR CREMATORIAL Arlington Memorial Cemetery		23d. LOCATION (City or Town) (County) MD.		(State)			
24. FUNERAL DIRECTOR Arlington S. Phillips		ADDRESS 1727 N. Market		25a. REC'D BY REGISTRAR OCT 24 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					



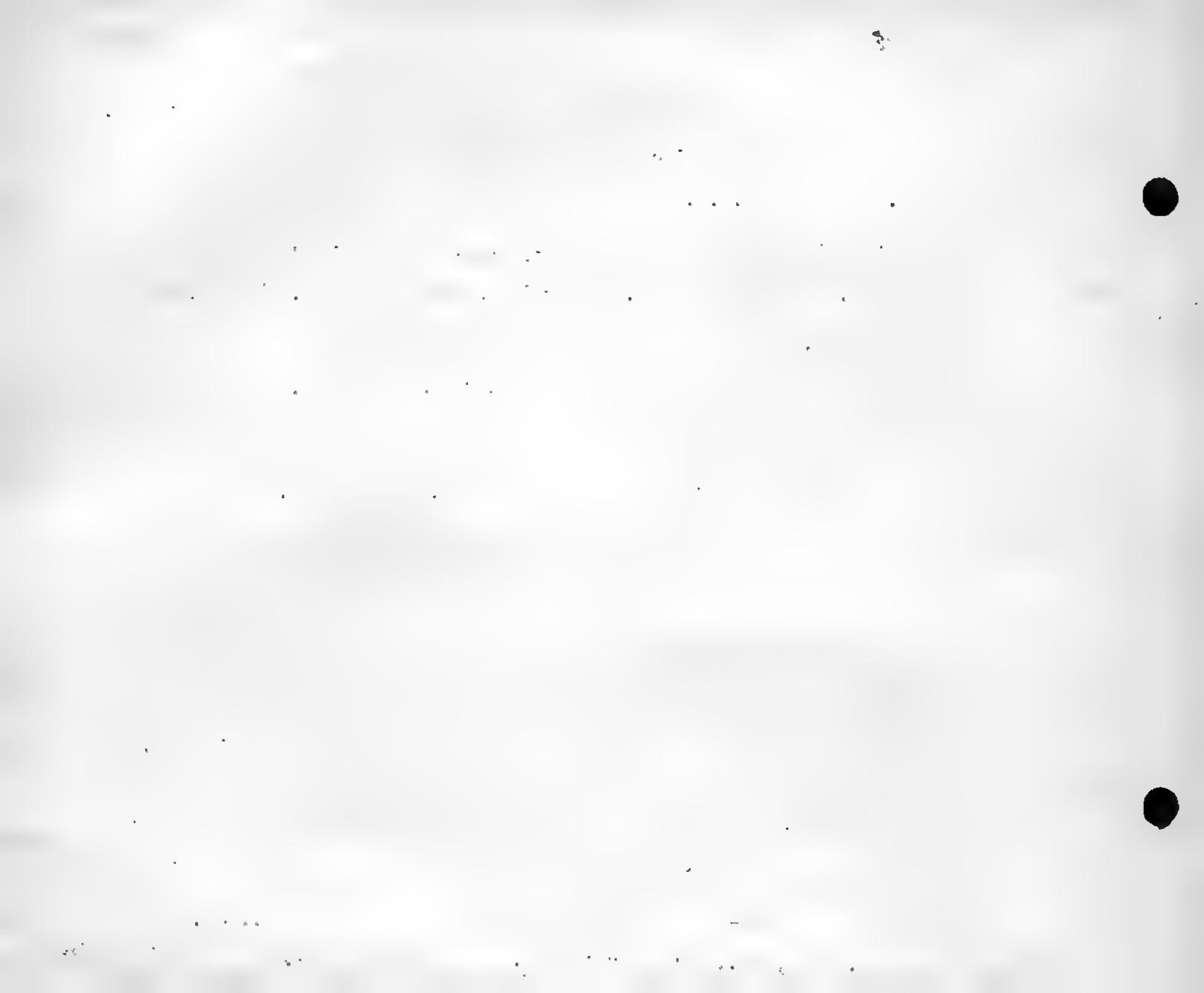
~~14058~~
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
~~CERTIFICATE OF DEATH~~

14069

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove suburban papers. Please send 2nd copy to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First MARY	Middle CATHERINE	Last LACHER	2a. DATE OF DEATH Month 10	Doy 26	Year 1968	2b. HOUR 9:00a.m.
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH 8/23/1899		6. AGE (in years last birthday) 69 yrs.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore		
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balt. Med. Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.		13b. CITY OR TOWN Balto.		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rt. 15, Box 692 Middle River		
14. FATHER'S NAME Robert E. Ward				15. MOTHER'S MAIDEN NAME Mary Gullery				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO		17. INFORMANT Albert V. Lacher, Sr.,		Address Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolus</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <u>129</u> <u>old myocardial infarct</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4/20/1								
19a. DATE OF OPERATION Hospital Certification		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>9/10</u> , 19 <u>68</u> , to <u>10/26</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>10/26/1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.								
22b. SIGNATURE <u>Charles C. Brown, M.D.</u>		DEGREE ATTENDING PHYS.	<input type="checkbox"/>	MED. DIRECTOR	<input type="checkbox"/>	STAFF PHYS.	<input checked="" type="checkbox"/>	22c. DATE SIGNED 10/26/68
22d. PHYSICIAN'S NAME (Type) Charles C. Brown, M. D.		22e. ADDRESS Greater Baltimore Medical Center						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-30-68		23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park		23d. LOCATION (City or Town) (County) (State) Balto., Md.		
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc., 5305 Harford Rd.		ADDRESS 25a. REC'D BY REGISTRAR DATE OCT 28 1968 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>						



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14070

14053

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)	First JANE	Middle S.	Last LAIRD	2a. DATE OF DEATH Month 10-30-68 Day Year 1968	2b. HOUR 2 A M
3 SEX FEMALE	4. RACE CAU	5. DATE OF BIRTH 9-28-16	6. AGE (In years last birthday) 52 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS M.M.	
7a BIRTHPLACE (State or foreign country) Penna.	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Baltimore	Md.	
10 CITY OR TOWN OF DEATH BALTIMORE, MD.	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GRTR. BALTO. MED. CENTER	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	12b KIND OF BUSINESS OR INDUSTRY Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) MARYLAND	13b. COUNTY BALTIMORE	13c CITY OR TOWN LUTHERVILLE	13d. INSIDE CITY LIMITS? YES	13e STREET AND NUMBER 405 FOX CHAPEL DRIVE	
14. FATHER'S NAME First Joseph W. Small, Jr.	Middle 	Last 	15. MOTHER'S MAIDEN NAME First Sara Shenefelt	Middle 	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No	16b. SOCIAL SECURITY NO. None	17. INFORMANT Family information	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) OSTEOLYTIC & OSTEOPBLASTIC METASTASES 114X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) IN THE PROXIMAL FEMUR WITH SEVERE ANEMIA (c) BREAST CARCINOMA APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) 114X					
19a. MEDICAL CERTIFICATION DATE 1900	19b. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, (OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from 10-06-68 , 19 68 , to 10-30 , 19 68 , that (I) (we) last saw the deceased alive on 10-30 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Dr. F. Naeim</i>	DEGREE ATTENDING PHYS.	22c. DATE SIGNED 10-30-68			
22d. PHYSICIAN'S NAME (Type) DR. F. NAEIM	22e. ADDRESS GBMC 6701 N. CHARLES ST.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Nov. 1, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Dulaney Valley Memorial	23d. LOCATION (City or Town) Cockeysville, Md.	(County)	(State)
24. FUNERAL DIRECTOR <i>John Morris Louis Lowood, Md.</i>	ADDRESS	25a. REC'D BY REGISTRAR NOV 4 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
VR A150 30M REV. 1-66					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14080

14071

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First MARGARET	Middle LOUISE	Last LAMBERT	2a. DATE OF DEATH OCT. Month 1 Day 68 Year	2b. HOUR 8:15
3 SEX FEMALE		4 RACE White		S. DATE OF BIRTH JANUARY 17, 1916	6. AGE (In years last birthday) 52 yrs.	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE	
10. CITY OR TOWN OF DEATH BALTIMORE		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GR. BALTO. MED. CENTER			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY —	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 3620 Hampden Ave.	
14. FATHER'S NAME First Edward		Middle L	Last Bigham	15. MOTHER'S MAIDEN NAME First Alice	Middle	Last MANN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO.		17 INFORMANT Elizabeth L. Fisher	Address 2960 Warwick Rd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CACKERTA & MALNUTRITION 1602 DUE TO, OR AS A CONSEQUENCE OF CARCINOMA OF MAXILLARY SINUS WITH (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) METASTASIS TO LUMBO VERTEBRA APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) RHEUMATIC HEART DISEASE WITH MITRAL COMMISSURE						
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) 19			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. GBMC	City or Town Baltimore	County Md	State
22a. I certify that (I) (this hospital) attended the deceased from OCT. 1, 1968 , to OCT. 1, 1968 , that (I) (we) last saw the deceased alive on OCT. 1, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>J. Joe</i>		DEGREE Y. JOE	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED 10-1-68
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 6701 N. CHARLES STREET				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE October 4, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Parkwood		23d. LOCATION (City or Town) Baltimore	(County) Md
24. FUNERAL DIRECTOR		ADDRESS Burgee Funeral Home, 3631 Falls Rd	25a. REC'D BY REGISTRAR DATE OCT 8 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. See Pages 1, 7 and 30 of the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM5 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14072

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)				First	Middle	Last	2d DATE KNOWN IF ESTI. DEATH MATED	Month	Day	Year	2d HOUR		
Giuseppe Sansone Lanasa							October 21, 1968	9 AM					
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 IF UNDER 1 YEAR MONTHS	8 IF UNDER 24 HRS DAYS	9 IF UNDER 24 HRS HOURS	10 IF UNDER 24 HRS MIN						
F	W	9/12/1877	91 YRS										
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
Italy		U.S.A.				Baltimore							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b KIND OF BUSINESS OR INDUSTRY	
Towson				St. Joseph's Hospital Homemaker				Homemaker				Own Home	
13a U.S. RESIDENCE (Where deceased lived, if institution admission) STATE				13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER					
Md.				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5003 Greenleaf Road					
14. FATHER'S NAME				First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last		
A.						Sansone	Anna				Catarnzro		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS					
No				217-32-8363A		Miss Anna J. Lanasa (Same)							
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>Hepatositic Pneumonia</i> APPROXIMATE INTERVAL Conditions, if any, which gave rise to immediate cause (o) <i>Generalized Arteriosclerosis</i> BETWEEN ONSET AND DEATH stating the underlying cause <i>and Diabetes Mellitus</i> <i>10 yrs</i> lost <i>Fractured Hip</i> <i>3 Months</i>													
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) <i>401</i>													
19a. DATE OF OPERATION <i>7/17/68</i>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Fractured Hip</i>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day Year HOUR A.M. <i>7/15/68</i> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Slide off chair in home.</i>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i>		21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Charles F. O'Donnell</i>		EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <i>10/21/68</i>			
23a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>				23b. DATE <i>10/25/68</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>New Cathedral</i>		23d. LOCATION (City or Town) <i>Baltimore</i>		(County) (State) <i>Md.</i>			
24. FUNERAL DIRECTOR <i>H.W. Jenkins & Sons Co.</i>				ADDRESS <i>4905 York Rd. Balto. 12, Md.</i>		25a. REC'D BY REGISTRAR <i>OCT 22 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14068

14073

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the hospital or attending physician, page 4 may be retained by the hospital or attending physician. Then please remove carbon papers. Pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Oct Month Doy / Year 68	2b. HOUR 8:10 A.M.
3 SEX M	4. RACE W	S. DATE OF BIRTH July 19, 1874	6 AGE (in years last birthday) 94 yrs.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Annapolis Md	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Robbs Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Painter & Painter	12b. KIND OF BUSINESS OR INDUSTRY Md.		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.	13b. COUNTY Baltimore	13c. CITY OR TOWN Md. STEVENSON	13d. INS-DE CITY LIM TSF YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER High Side Rd, STEVENSON	
14. FATHER'S NAME Edward	First	Middle	Last	15. MOTHER'S MAIDEN NAME HARRIMORE	Middle
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. None	17 INFORMANT Mr. Alfred Norman Lawrence, Hillside	Address Stevenson, Md.	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) ASC.V.D. 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) B.P.H.					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>3 August</u> , 19 <u>56</u> , to <u>1 Oct</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>15 Sept</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Charles H. Williams	DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) Charles H. Williams, M.D.	22e. ADDRESS Pikesville, 21208, Md.				
23a. BURIAL, CREMATION OR Cremation REMAVAL (Specify) Burial Oct. 4, 1968	23b. DATE ADDRESS	23c. NAME OF CEMETERY OR CREMATORIUM Stone Chapel Cemetery	23d. LOCATION (City or Town) Pikesville	(County) Baltimore	(State) Md.
24. FUNERAL DIRECTOR Frank H. Jewell, Pikesville, Md.	25a. REC'D. BY REGISTRAR DATE OCT 2 1968				
25b. REG. STAR'S SIGNATURE Charles Judge					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14074

16063

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, **1** funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month	Doy	Year	2b. HOUR	
<i>Francis</i>	<i>W</i>	<i>Lawrence</i>	<i>Jr</i>	<i>Oct</i>	<i>26</i>	<i>68</i>	<i>6:45 PM</i>	
3. SEX	4 RACE	S. DATE OF BIRTH	6. AGE (In years lost birthday)	IF UNDER 1 YEAR			IF UNDER 24 HRS	
<i>Male</i>	<i>Caucasian</i>	<i>7-29-1889</i>	<i>79 yrs.</i>	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH					
<i>Md</i>	<i>Balt. City</i>		<i>Balt Co. Md.</i>					
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
<i>Balt Co. Randallstown</i>	<i>Balt. Co. Gen. Hosp.</i>			<i>Railroad</i>		<i>Railroad</i>		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER				
<i>Md.</i>	<i>Baltimore</i>	<i>Baltimore</i>	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<i>5531 Bosworth Ave</i>			
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last	
<i>Francis W.</i>	<i>Lawrence</i>	<i>SR</i>		<i>Anne</i>	-	<i>Appleby</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	16b. SOCIAL SECURITY NO	17 INFORMANT	Address					
<i>Yes</i>	<i>WWI</i>	<i>217-09-85034 MRS Edith Horan</i>	<i>Baltimore, Md.</i>					
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).)								
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>CHRONIC OBSTRUCTIVE LUNG DISEASE</i>								
491X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any which gave rise to immediate cause (a), stating the underlying cause (b) <i>CHRONIC BRONCHITIS AND EMPHYSEMA</i>								
DUE TO, OR AS A CONSEQUENCE OF (c)								
491X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any which gave rise to immediate cause (a), stating the underlying cause (b) <i>CHRONIC BRONCHITIS AND EMPHYSEMA</i>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
<i>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</i>								
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
			<input type="checkbox"/> YES	<input type="checkbox"/> NO				
21a. ACCIDENT WAS UNDERLYING	21b. TIME OF INJURY HOUR A.M. Month Doy Year P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
<input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	<i>19</i>							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <i>10/10</i> , 19 <i>68</i> , to <i>10/26</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>10/22 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE	<i>Reve P. de la Sante</i>			DEGREE	ATTENDING PHYS.	<input type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (Type)	<i>Reve P. de la Sante</i>			ADDRESS	<i>Randallstown, Md.</i>			<i>10/26/68</i>
23a. BURIAL, CREMATION REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION (City or Town)	(County)		(State)		
<i>cremated</i>	<i>10-28-68</i>	<i>Woodlawn</i>	<i>Baltimore</i>					
24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE					
<i>Harry W. Haight</i>	<i>Sykesville, Md.</i>	<i>OCT 31 1968</i>	<i>Charles Judge</i>					



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 to the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11066 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14075

1. DECEASED NAME (Type or Print)			First JERRY	Middle NIAH	Last LEE	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	Month 10	Day 20	Year 68 19	2b. HOUR 7:35 AM	
3. SEX M	4. RACE BLACK	S. DATE OF BIRTH 7-12-15	6. AGE IN YEARS last birthday) 53 yrs	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS						
				HOURS	MIN.	2c. DATE PRONOUNCED DEAD Month 10	Day 20	Year 68 19	2d. HOUR 8:00 AM		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY? W.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE						
10. CITY OR TOWN OF DEATH Sparrows Pt. MD		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Steel Disp Bn Engr Helper			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if refred.) Steel			12b. KIND OF BUSINESS OR IND-STRY Steel			
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE MD.		13b. COUNTY BALT.		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1552 MCKEAN Ave					
14. FATHER'S NAME George W. Lee Sr.		15. MOTHER'S MAIDEN NAME Sarah BRAGGINS									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 246-05-0665		17. INFORMANT ADD 18 Hampshire Reservoir		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO, OR AS A CONSEQUENCE OF 2509 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) A-S-C-V-Disease DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) X 1										—	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) No							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE M.B. Davis		MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 10/20/68	
EXAMINER'S NAME (Type) M.B. Davis MD - 6800 Maryland Ave - Burtonsville MD		ADDRESS		ADDRESS (Street, city, town, or county)		ADDRESS (Street, city, town, or county)		(City)		(State)	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/24/68		23c. NAME OF CEMETERY OR CREMATORIAL Corcoran Mortuaries		23d. LOCATION (City or Town) Maryland		23e. COUNTY		23f. STATE	
24. FUNERAL DIRECTOR Marshall Phillips 685 n G. St.		ADDRESS		25a. REC'D BY REGISTRAR OCT 22 1968		25b. REGISTRAR'S SIGNATURE Charles J. ...		DATE		TIME	
VR AT SME (5) 10M REV 1/66											



1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

N.E. notified - released as none Med.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item 1 per tele. cert. 10/23/68 CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR				
WILLIAM		F.	Leineweber	S.R.	Month	Day	Year	10 20 1968 7:30AM			
3. SEX		4 RACE	Cauc	5. DATE OF BIRTH		6. AGE (In years last birthday)			IF UNDER 1 YEAR		
Male				09 01 1895		73 YRS.			MONTHS	DAYS	IF UNDER 24 HRS MD.HRS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Maryland		U. S. A.				Baltimore					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore		GBMC, Towson, Md.		Proprietor-Contractor Heating							
13a. USUAL RESIDENCE (Where deceased lived, if institution- Res dence before admission) STATE		13c. CITY OR TOWN		13d. INSIDE C.TY LIMITS?		13e. STREET AND NUMBER					
Maryland		Baltimore		Towson		YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	204 E.Joppa Road			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last		
		F		Leineweber			Margaret		White		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH					
No				Wm.F. Leineweber, Jr., 62 Woodvale Ave.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Fibrillation											
DUE TO, OR AS A CONSEQUENCE OF Ruptured Abdominal Aneurysm											
(b) DUE TO, OR AS A CONSEQUENCE OF last											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
10-20-68		Aneurysm Ruptured Abdominal		YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> D.R. CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State		
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <u>10-20</u> , 19 <u>68</u> , to <u>10-20</u> , 19 <u>68</u> , that <input type="checkbox"/> (we) last saw the deceased alive on <u>10-20</u> , 19 <u>68</u> , and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.											
22b. SIGNATURE		<i>Dr. Eduardo Canilang M.D.</i>		DEGREE	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type)		Dr. Eduardo Canilang M.D.		G.B.M.C. 6701 N. Charles St. 21204					10-20-68		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City or Town)		(County)		(State)	
Burial		10/23/68		Dulaney Valley Mem. Grds.		Timonium, Balto. Co., Md.					
24. FUNERAL DIRECTOR		ADDRESS		25a. RECED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
H.W. Jenkins & Sons Co.		4905 York Rd. Balto. 12, Md.		DATE OCT 21 1968		<i>Charles Judge</i>					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14077

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

1. DECEASED NAME (Type or print)	First CARL	Middle L	Last LESCALLEET	2a. DATE OF DEATH 10 Month 17 Day 68 Year	2b. HOUR 2:50 P.M.
3. SEX MALE	4. RACE White	5. DATE OF BIRTH Aug. 9, 1890		6. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH BALTIMORE		
10. CITY OR TOWN OF DEATH BALTIMORE	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GREAT. BALT. MED. CEN.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Farmer - Retired	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Route 2	
14. FATHER'S NAME George L. Lescalleet	First MIDDLE L.	15. MOTHER'S MAIDEN NAME Jennie	Middle Bair	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. 216-14-5359	17. INFORMANT Mrs. Margaret A. Stamhaugh	Address R.D. 5 West. Md.	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) RESPIRATORY ARREST FOLLOWED BY CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CARDIO VASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF (c) AN ACUTE MYOCARDIAL INFARCTION WITH ARRHYTHMIA & HYPERTENSION					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from 10/14, 19 68 to 10/17, 19 68, that (I) (we) last saw the deceased alive on 10/17 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Gihan Tenneko		DEGREE ATTENDING PHYS	22c. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	DATE SIGNED 10-17-68	
22d. PHYSICIAN'S NAME (Type) GIHAN TENNEKOON, M.D.		22e. ADDRESS 6701 N CHARLES ST BALTIMORE, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/19/1968	23c. NAME OF CEMETERY OR CREMATORIAL Taylorsville	23d. LOCATION (City or Town) Carroll, Md.	(County) (State)
24. FUNERAL DIRECTOR C. M. Waltz, Box 241, Sykesville, Md.		ADDRESS		25a. REC'D BY REGISTRAR OCT 21 1968	25b. REC'D BY CLERK'S SIGNATURE John J. George
VR A15 30M REV					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14078

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1, Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14067		First Mary	Middle H.	Lost Liming	Date Known Month Day Year 10-20-19	2b. HOUR 3A. M.
3 SEX Female	4 RACE White	5 DATE OF BIRTH May 19, 1903	6 AGE (in years last birthday) 65 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year October 20 1968	2d HOUR 10 A.M.
7a BIRTHPLACE (State or foreign country) Pennsylvania		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Baltimore	
10 CITY OR TOWN OF DEATH Dundalk		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7006 Mornington Road		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife		12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE Maryland		13b. COUNTY Baltimore	13c CITY OR TOWN Dundalk	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER 7006 Mornington Road	
14 FATHER'S NAME Michael J. Reigle		15 MOTHER'S MAIDEN NAME Lucy				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO 419-20-4546		17 INFORMANT (Sister) Mrs. Helen Leftwich, 7006 Mornington Rd.		ADDRESS Dundalk, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A-S-C-V-DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)						
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>422 Chronic Nephritis & Left Nephrectomy</u>						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b) <u>Me</u>		
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building etc)		21f. LOCATION Street or R.F.D. No	City or Town	County State
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <u>Melvin B. Davis</u>		EXAMINER'S NAME (Type) Melvin B. Davis		CHIEF MEDICAL EXAMINER <input type="checkbox"/> 6800 Mornington Road M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) Dundalk, Md. 21222		
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 10/23/68		23c NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		23d LOCATION (City or Town) (County) (State) Hanover, Penna.
24 FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		ADDRESS		25a REC'D BY REG STRR DATE OCT 24 1968		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14068

14079

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 3 and 2, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First ARTHUR	Middle W.	Last LINCK	2a. DATE OF DEATH October Month 26, Day Year 1968	2b. HOUR 4:30 A.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH April 7, 1895		6. AGE (In years last birthday) 73 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Baltimore		
10. CITY OR TOWN OF DEATH Lansdowne	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 339 - 5th Avenue		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Butcher		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institut'ion. Res dence before admission) STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Lansdowne	13d. INSIDE CITY, MTS? YES NO	13e. STREET AND NUMBER 339 - 5th Avenue	
14. FATHER'S NAME Henry J. Linck	First Middle Last	15. MOTHER'S MAIDEN NAME First Amelia Wagner		Middle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. 217-01-0270	17. INFORMANT Mrs. Margaret E. Linck, 339 5th Avenue	Address 21227		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of the esophagus</u> APPROXIMATE INTERVAL DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) <u>with metastasis</u> BETWEEN ONSET AND DEATH 1/2 yrs.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1/2 yrs.					
19a. DATE OF OPERATION X	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>3/1/67</u> to <u>10/26/68</u> , that (I) (we) last saw the deceased alive on <u>10/24/68</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Herbert J. Levickas, M.D.</i>	ATTENDING DEGREE PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 10/26/68			
22d. PHYSICIAN'S NAME (Type)	Dr. Herbert J. Levickas	22e. ADDRESS 5404 East Drive, Baltimore, Md. 21227			
23a. BURIAL, CREMATION, BURIAL (Specify)	23b. DATE 10-29-1968	23c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cemetery	23d. LOCATION (City or Town) Baltimore, Maryland	(County)	(State)
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave.	ADDRESS 21229	25a. REC'D BY REGISTRAR DATE OCT 28 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14080

13063

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

DECEASED NAME (Type or print)	First Minnie	Middle E.	Last Linde	20. DATE OF DEATH Month 10 Day 29 Year 68	26 HOUR 12'51 AM
3. SEX F	4 RACE W	S. DATE OF BIRTH 3/23/85	6. AGE (In years last birthday) 83 YRS	F UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) GERMANY	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore	10. CITY OR TOWN OF DEATH Baltimore 21228	
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Summit Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Office stck		12b. KIND OF BUSINESS OR INDUSTRY Baltimore Police Ad	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD	13b. COUNTY HOWARD COUNTY	13c. CITY OR TOWN ELKTON CITY	13d. INSIDE CTY J.M.T.S? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Belair Drive 1200	
14. FATHER'S NAME KARL WENDELER	First	Middle	Last	15. MOTHER'S MAIDEN NAME First DRAUDT	Middle
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO (If yes give war or dates of service)	17. INFORMANT RUDOLPH LINDE - III	Address Hillside Rd -		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of Uterine Bladder From Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost metastasis see to above 5 yrs					
DUE TO, OR AS A CONSEQUENCE OF (b) metastasis see to above 5 yrs					
DUE TO, OR AS A CONSEQUENCE OF (c) See anterior clitoris years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from 8-22 , to Oct 29 , 19 68 , that (I) (we) last saw the deceased alive on 10-20 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Manuel de la Torre		DEGREE MANUEL DE LA TORRE	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22c. DATE SIGNED 10-29-68					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 1424 Sulphur Spring Rd Baltimore MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 10/31/68	23c. NAME OF CEMETERY OR CREMATORIAL Lorraine	23d. LOCATION (City or Town) BALTIMORE CO MD	(County) (State)
24. FUNERAL DIRECTOR MACNAB & SON		ADDRESS 21228	25a. REC'D BY REGISTRAR DATE NOV 1 1968		25b. REGISTRAR'S SIGNATURE Charles Judge

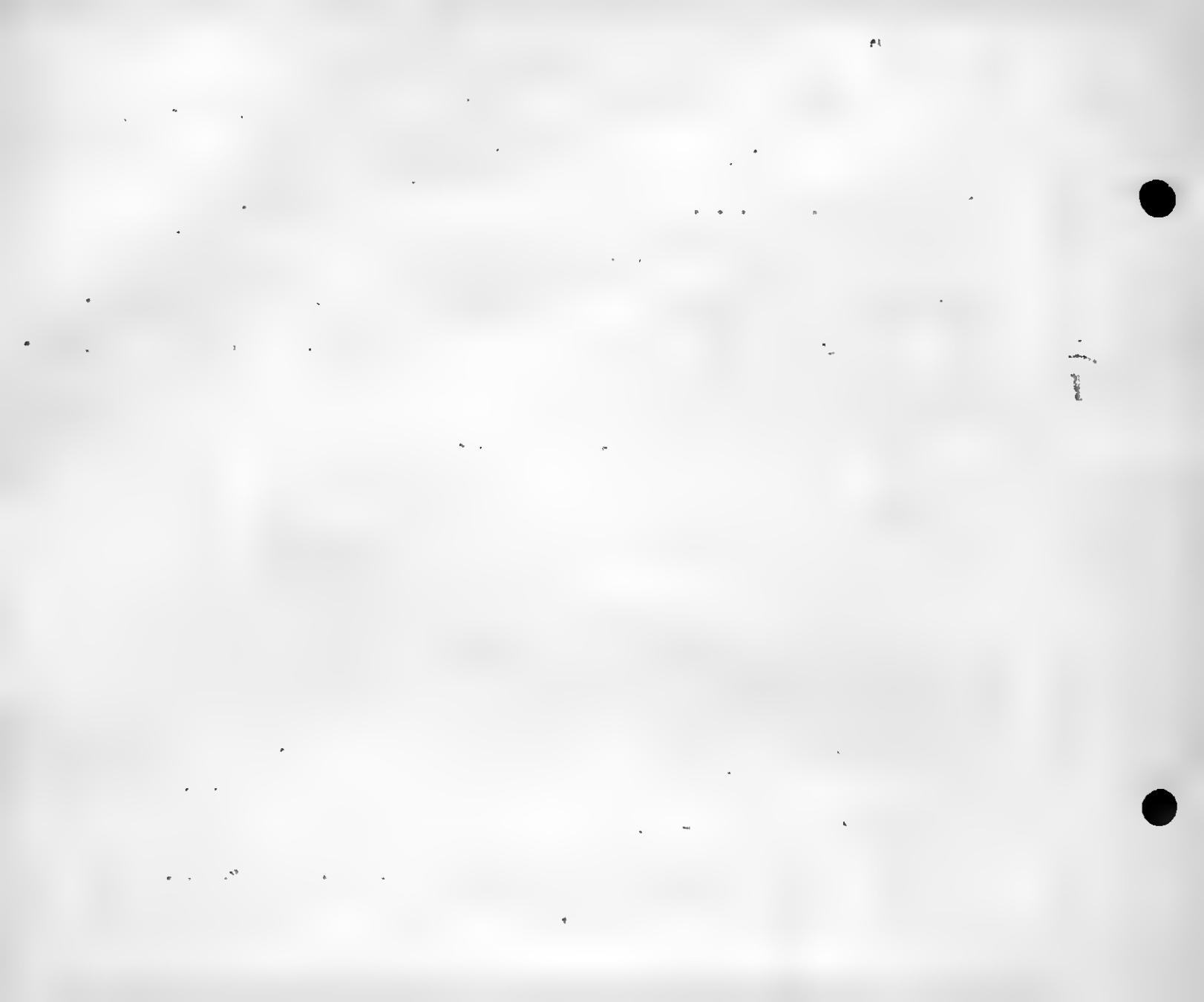
200

Item23b FilmG407 12/3/68 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 14070 CERTIFICATE OF DEATH 15616

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy pages 1 and 2, which should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)	First Racquel	Middle Eugenia	Last Mabus	20. DATE OF DEATH Month 10	Day 31	Year 1968	2b. HOUR 2:15 AM	
3 SEX Female	4. RACE White		S. DATE OF BIRTH 10/29/68	6. AGE (In years last birthday) YRS. 2		IF UNDER 1 YEAR MONTHS 2		
7a BIRTHPLACE (State or foreign country) Baltimore, Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Baltimore,		Md.		
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 3015 Putty Hill Ave.				
14. FATHER'S NAME First Howard	Middle John	Last Mabus	15. MOTHER'S MAIDEN NAME First Frances	Middle Jean	Last Canavan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral Hemorrhage 772 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Prematurity & Anoxia DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7605								
19a. DATE OF OPERATION 7605	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)	21f. LOCATION Street or R.F.D No.	City or Town	County	State			
22. I certify that I (this hospital) attended the deceased from 10/29/68 , to 10/31/68 , that I (we) last saw the deceased alive on 10/31/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE CHARLES A. FELICIANO, M.D.	22c. DATE SIGNED 10/31/68							
22d. PHYSICIAN'S NAME (Type) CHARLES A. FELICIANO, M.D.	22e. ADDRESS 7620 York Rd., Towson, Md. 21204							
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 11/19/68	23c. NAME OF CEMETERY OR CREMATORIAL Anatomy Board of Maryland	23d. LOCATION (City or Town) Baltimore, Maryland	(County) Baltimore, Maryland	(State)			
24. FUNERAL DIRECTOR	ADDRESS		25a. REC'D BY REGISTRAR NOV 21 1968	25b. REGISTRAR'S SIGNATURE Charles J. Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

NO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**
CERTIFICATE OF DEATH

14081

I DECEASED-NAME (Type or print)			First	Middle	Last	2d. DATE OF DEATH	2b. HOUR						
Robert Stewart MacEwan			Month	Day	Year								
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Male		White		June 30, 1906		62		MONTHS	DAYS	HOURS	MIN		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md					
Scotland		U.S.A.				Baltimore							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY				
Ruxton			8415 Bellona La.			Manager Dept. Store							
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13c. CITY OR TOWN			13d. INSIDE CITY, JM TS?		13e. STREET AND NUMBER					
Maryland			Baltimore			Ruxton		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		8415 Bellona La. Apt. 802			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last		
John			MacEwan			Jean			Gray				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address				
Yes			WWII			Mrs. Doris St. Jean MacEwan Ruxton Towers 802			Apt. 6 months				
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1. _____													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
8/68		Above				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from 5, 1959, to 10/22, 1968, that (I) (we) los saw the deceased alive on 10/22, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE			Alan Bernstein			DEGREE	ATTENDING PHYS	<input checked="" type="checkbox"/>	MED DIRECTOR	<input type="checkbox"/>	STAFF PHYS.	22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS									10/23/68	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National Cem.				23d. LOCATION (City or Town)		(County)		(State)	
Burial		10/25/68						Baltimore, Maryland					
24. FUNERAL DIRECTOR						ADDRESS		25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Wm. Cook-Brooks Towson 1050 York Rd. 21204								DATE OCT 24 1968		Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14082

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Address and telephone number should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)	First JULINS	Middle	Last MACKS	2a. DATE OF DEATH Month Oct Day 31 Year 68 6:00 P.M.	2b. HOUR		
3. SEX MALE	4 RACE WHITE	5. DATE OF BIRTH 12-12-1896	6 AGE (In years last birthday) 71 YRS.	7 IF UNDER 1 YEAR MONTHS	8 IF UNDER 24 HRS DAYS	9 IF UNDER 24 HRS HOURS	10 MIN
7a. BIRTHPLACE (State or foreign country) NEW YORK	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE				
10. CITY OR TOWN OF DEATH PIKESVILLE	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MILFORD MANOR NURSING HOME			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) SALESMAN		12b. KIND OF BUSINESS OR INDUSTRY REAL ESTATE	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND	13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 2502 APACHE CIRCLE			
14. FATHER'S NAME MAX	MIDDLE JOSEPH	LAST MACKS	15. MOTHER'S MAIDEN NAME ROSE	MIDDLE	LAST LEVINSON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES	16b. SOCIAL SECURITY NO W.W. I	17. INFORMANT MORTON MACKS - 6100 BENHURST ROAD	Address APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min				
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Congestive Heart Failure</u> (b) <u>Coronary Artery Disease (Atherosclerosis)</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Heart Disease</u>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) CVA - Old left Rampeigd							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20d. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At Home, Farm, Street, Factory, Office Building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from <u>1954</u> , to <u>10/31, 1968</u> , that (I) (we) last saw the deceased alive on <u>10/27 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE George Sharfatz M.D.	DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 10-31-68			
22d. PHYSICIAN'S NAME (Type) GEORGE SHARFATZ	22e. ADDRESS 6400 Park Heights Ave.						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE NOVEMBER 1168	23c. NAME OF CEMETERY OR CREMATORIAL HEBREW FRIENDSHIP	23d. LOCATION (City or Town) BALTIMORE, Md		(County) (State)		
24. FUNERAL DIRECTOR SOL LEVINSON & BEASIDE - 6000 REISTERSTOWN RD	ADDRESS	25a. REC'D BY REGISTRAR NOV 6 1968	25b. REGISTRAR'S SIGNATURE j Charles Judge				
VR A15 (4) 304 REV 1/68							



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13
16073

14083

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 and 2 hours after death. Should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours of death.

1. DECEASED-NAME (Type or print)	First <i>Joseph</i>	Middle <i>Major</i>	Last <i>Major</i>	2a. DATE OF DEATH Month <i>Oct.</i>	Day <i>2, 1968</i>	2b. HOUR <i>M</i>		
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>Nov. 19, 1881.</i>		6. AGE (In years last birthday) <i>86</i>	IF UNDER 1 YEAR MONTHS <i>0</i>		IF UNDER 24 HRS. HOURS <i>0</i>	
7a. BIRTHPLACE (State or foreign country) <i>Hungary</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Baltimore</i>		
10. CITY OR TOWN OF DEATH <i>Parkville</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>9637 Dixon Ave.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired - Railroad Worker</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Railroad Worker</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>Balto.</i>	13c. CITY OR TOWN <i>Baltimore</i>	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER <i>9637 Dixon Avenue</i>				
14 FATHER'S NAME First <i>Anthony</i>	Middle <i>Major</i>	Last <i>Rose</i>	15. MOTHER'S MAIDEN NAME First <i>Rose</i>	Middle <i>?</i>	Last <i>?</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no <i>No</i>	16b. SOCIAL SECURITY NO <i>716-09-4358</i>	17. INFORMANT <i>Mrs. Rose Keane</i>	Address <i>(Same)</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>+129</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4521</i>								
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerotic Cardiovascular Disease.</i>								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Recent anorexia and weakness (not ambulating)</i>								
19a. DATE OF OPERATION <i>1968</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Amputation</i>	20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Not</i>					
21a. ACCIDENT WAS UNDER, IN, OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <i>While at work</i>	21b. TIME OF INJURY Hour A.M. Month Day Year <i>1968</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Injury</i>						
21d. INJURY OCCURRED While at work <i>at work</i>	21e. PLACE OF INJURY (At Home, Farm, Street, Factory, Office Building, Etc.) <i>Office Building</i>	21f. LOCATION Street or R.F.D. No. <i>1000 HARFORD RD</i>	City or Town <i>Harrisburg, Pa.</i>	County <i>Dauphin Co.</i>	State <i>Pa.</i>			
22a. I certify that (I) This hospital attended the deceased from saw the deceased alive on <i>Oct. 1968</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Kasik Jr. MD</i>	DEGREE ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <i>10/3/68</i>				
22d. PHYSICIAN'S NAME (Type) <i>F.T. KASIK JR.</i>	22e. ADDRESS <i>1000 HARFORD RD</i>							
23a. BURIAL, CREMAT. ON, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>10/7/68.</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Holy Cross Cemetery</i>	23d. LOCATION (City or Town) (County) <i>Harrisburg, Pa.</i>	(State) <i>Pa.</i>				
24. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc. Balto. Md. 21214</i>	ADDRESS	25a. DEATH REGISTRATION DATE <i>Oct 4 1968</i>	25b. REGISTERED STATE <i>Penns. Judge</i>					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14084

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First James	Middle David	Last Manning	2a. DATE OF DEATH Month Oct.	2b. HOUR 11				
3 SEX Male		4. RACE White		S. DATE OF BIRTH Dec. 31, 1924	6. AGE (In years last birthday) 45	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	2b HOUR HOURS 0		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore					
10. CITY OR TOWN OF DEATH Rosedale		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 8432 Coco Road			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Accountant			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Rosedale	13d. INSIDE CITY LIMITS? YES	13e. STREET AND NUMBER 8432 Coco Road.					
14. FATHER'S NAME James		Middle Manning	Last Lida							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes		16b. SOCIAL SECURITY NO. 218-18-5715		17. INFORMANT Mrs. Barbara Manning		Address 8432 Coco Road.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY										
IMMEDIATE CAUSE (a) Cardiac arrest										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Carcinoma of the rectum										
DUE TO, OR AS A CONSEQUENCE OF										
(c) with metastasis of the liver										
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)										
1539 Cachexia										
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/>	NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At Home, Farm, Street, Factory, Office Building, Etc.)		21f. LOCATION Street or R.F.D. No. 1011	City or Town Philadelphia	County Philadelphia	State PA			
22a. I certify that (I) (this hospital) attended the deceased from mid Sept., 1968 , to his death , that (I) (we) last saw the deceased alive on 10/11/1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE John Geldrich MD										
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22c. DATE SIGNED 10/12/68						
John Geldrich, M.D.		8019 Philadelphia Road.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct. 15, 1968		23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National Cem.		23d. LOCATION (City or Town) Baltimore, Md.		(County) Baltimore, Md.	(State) Md.	
24. FUNERAL DIRECTOR Ulrich Funeral Home 2112 Dundalk, Ave.		ADDRESS		25a. REC'D BY REGISTRAR OCT 16 1968		25b. REGISTRAR'S SIGNATURE Charles George				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14085

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First RUTH	Middle MULLIKEN	Lost MARBURY	2a. DATE OF DEATH Month 10	Day 31	Year 1968	2b HOUR 2:10a M
3 SEX Female	4. RACE Caucasian	5. DATE OF BIRTH 4/5/13			6 AGE (In years last birthday) 55 YRS.	F JUNIOR 1 YEAR MONTHS	H UNDER 24 HRS DAYS
7a BIRTHPLACE (State or foreign country) Rye, N. Y.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	B MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Baltimore				
10 CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Med. Center			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (Where deceased admission) STATE Md.	lived, if institution: Residence before 13b. COUNTY Balto.	13c. CITY OR TOWN Towson	13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 622 Charles St. Ave.			
14. FATHER'S NAME Harral	First Middle Mulliken	15. MOTHER'S MAIDEN NAME Taylor M. Marbury	16. SOCIAL SECURITY NO. 579-09-1640			Address (Same)	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No				17. INFORMANT Taylor M. Marbury			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 1579 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				Carcinoma pancreas with widespread metastases DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 157X							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from 10/28, 1968, to 10/31, 1968, that (I) (we) last saw the deceased alive on 10/31, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) (did not) view the body after death.							
22b. SIGNATURE Charles C. Brown, M.D.		DEGREE	ATTENDING PHYS.	<input type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED October 31, 1968	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS Greater Baltimore Medical Center					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 10/31/68	23c. NAME OF CEMETERY OR CREMATORIAL Greenmount		23d. LOCATION (City or Town) Baltimore		
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4005 York Rd. Balto. Md.	25a. REC'D BY REGISTRAR NOV 4 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14076

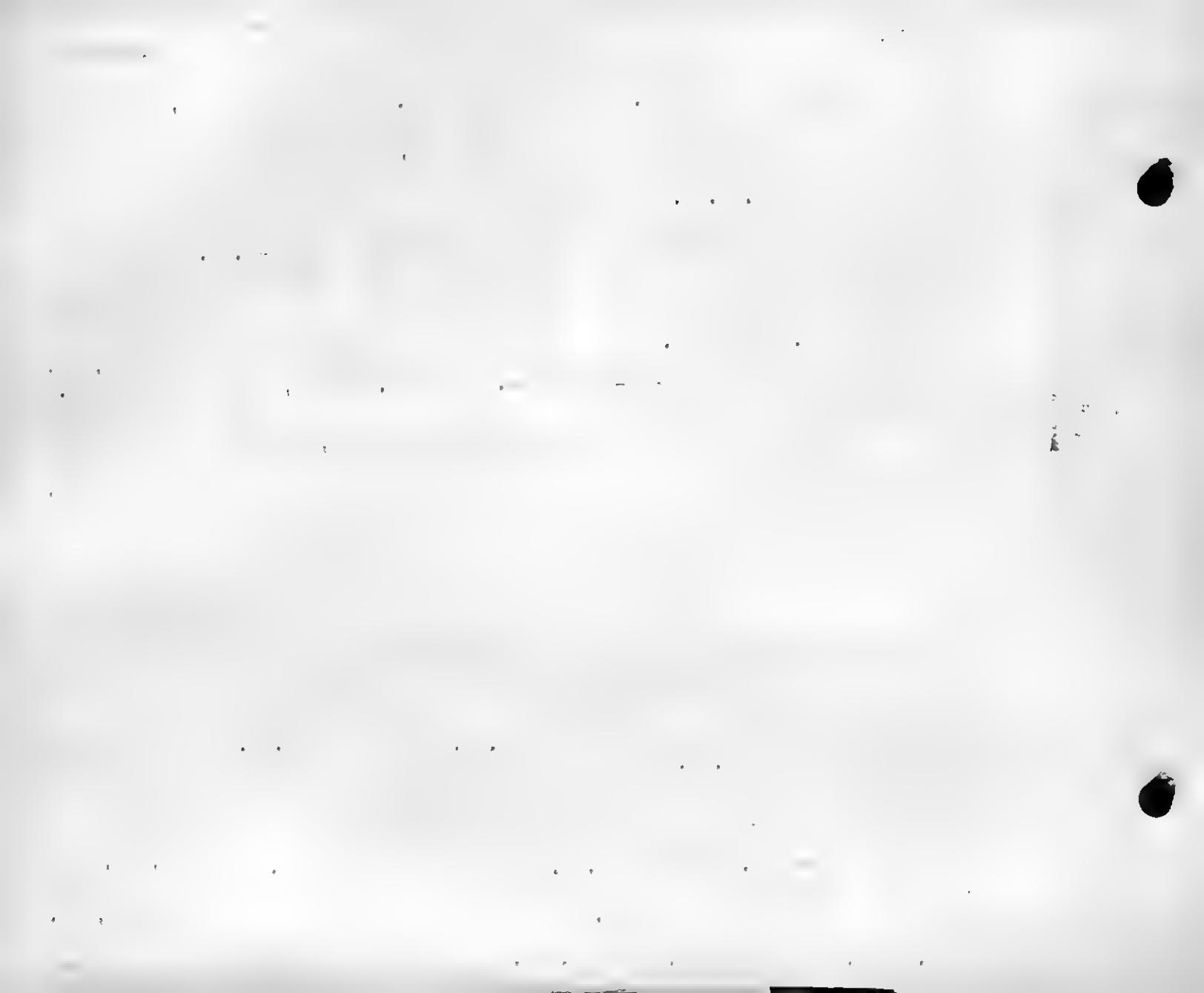
CERTIFICATE OF DEATH

14086

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or interment, and in any event, within 24 hours after death.

1 DECEASED NAME (Type or print)		First Ralph	Middle J.	Lost Martin Jr.	20. DATE OF DEATH Month October Day 1, 1968	2b HOUR M	
3 SEX Male		4 RACE White		5 DATE OF BIRTH April 16, 1919		6 AGE (in years last birthday) 49 yrs.	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore	
10 CITY OR TOWN OF DEATH Dundalk		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 8124 Longpoint Road		12a USLA. OCCUPATION (Kind of work done during most of working life, even if retired) Truck Driver-W. D. Cowan		12b KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 8124 Longpoint Road	
14. FATHER'S NAME First Ralph J. Martin Sr.		5 MOTHER'S MAIDEN NAME First Middle Mary Helen Keihley					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown WWII		16b SOCIAL SECURITY NO 217-09-0677		17 INFORMANT (Wife) Mrs. Sheila P. Martin, 8124 Longpoint Rd.		Address Dundalk, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		metastatic adenocarcinoma, pancreas				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 mos	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF diabetes mellitus				6 mos.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a DATE OF OPERATION 157 X		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour AM Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>11.17.56</u> , 19_____, to <u>9.25.68</u> , 19_____, that (I) (we) last saw the deceased alive on <u>9.25.68</u> , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <i>Eugene F. Nevy MD</i>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c DATE SIGNED 10/2/68		
22d PHYSICIAN'S NAME (Type)		22e ADDRESS 7001 Mornington Rd.		Dundalk, Md. 21222			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 10/4/68		23c NAME OF CEMETERY OR CREMATORIAL Balto. National Cemetery		23d LOCATION (City or Town) (County) Baltimore, Md. (State)	
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE OCT 7 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 5 Film G105 CERTIFICATE OF DEATH

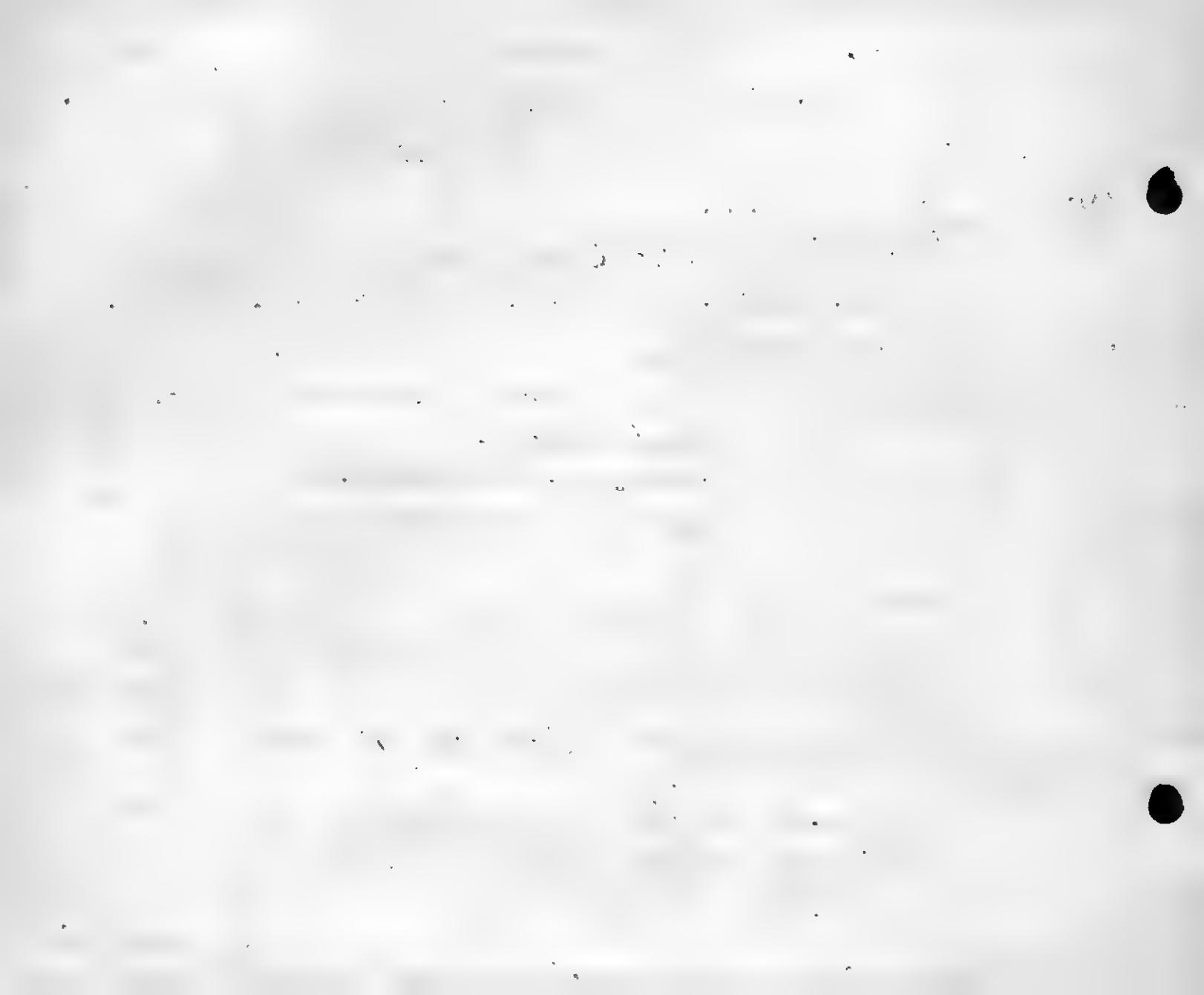
14077

14087

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First CORA	Middle	Last MATHANEY	2a. DATE OF DEATH Month 10 Year 1968	2b. HOUR 10 AM
3 SEX FEMALE	4 RACE WHITE	S. DATE OF BIRTH 11-28-1885	5 AGE (In years last birthday) 83	6 IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN. 0	
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9 COUNTY OF DEATH BALTIMORE		
10 CITY OR TOWN OF DEATH TOWSON	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CHESAPEAKE MANOR	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13c CITY OR TOWN Towson	.3d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER 1200 Providence Rd.		
14. FATHER'S NAME George W. Leonard	15 MOTHER'S MAIDEN NAME Mollie	16. SOCIAL SECURITY NO.	17 INFORMANT Edgar H Mathaney	Address 1321 Roxboro Rd. 21237	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> (b) <u>Generalized arterioclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Dehydration due to disease</u>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. MEDICAL CERTIFICATION DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>June 20, 1968</u> , to <u>Oct 9, 1968</u> , that (I) (we) last saw the deceased alive on <u>Oct 9, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE James H. Hauer, MD	DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (Type) James H. Hauer, MD	22e. ADDRESS Towson, MD				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/14/68	23c. NAME OF CEMETERY OR CREMATORIAL Garden of Faith Cem	23d. LOCATION (City or Town) Baltimore	(County) Md.	(State)
24 FUNERAL DIRECTOR Lassahn Funeral Home	ADDRESS 7401 Belair Rd. 21236	25a. REC'D BY REGISTRAR DATE OCT 14 1968	25b. REGISTERED SIGNATURE George J. Lassahn		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by hand, and 2 director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. If any event, within 72 hours and death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

14073

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14088

1. DECEASED NAME (Type or print)	First Marie , Middle N. Last Mattison	2a DATE OF DEATH Oct. 5 Month Year 1968	2b HOUR 11:55AM		
3. SEX Female	4. RACE White	5. DATE OF BIRTH 8/14/96	6. AGE (In years old birthday) 72 yrs		
7a BIRTHPLACE (State or foreign country) Balto.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Balto. County General	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13b. COUNTY Baltimor .	13c. CITY OR TOWN Balto. 7	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e STREET AND NUMBER 7514 windsor Mill Rd.					
14. FATHER'S NAME First John	Middle Helmer	15. MOTHER'S MARRIED NAME First Louisa	Middle Botenberg		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO 219-18-8475	17 INFORMANT Mrs Dorothy L. Zimmerman	Address 7514 windsor Mill Rd.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intractable Left Ventricular Failure 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarctions X 2 DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Cardiovascular Disease					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201					
19a. DATE OF OPERATION MEDICAL CERTIFICATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from Sept 20 1968, to Oct 5 1968, that (I) (we) last saw the deceased alive on Oct 5 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.					
22b SIGNATURE	DEGREE ATTENDING PHYS	<input type="checkbox"/>	MED. DIRECTOR	<input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22d PHYSICIAN'S NAME (Type)	22e. ADDRESS Balto Co. General Hospital	22c. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL, (Specify)	23b. DATE Oct. 8, 1968	23c. NAME OF CEMETERY OR CREMATORIY Mt Olive Cemetery	23d. LOCATION (City or Town) Randallstown, Md.	(County)	(State)
24. FUNERAL DIRECTOR Young Byers 8728 Liberty Road.	ADDRESS	25a. FILED BY REGISTRAR OCT 8 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14089

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First <i>CHARLES</i>	Middle <i>P.</i>	Last <i>MC GEENEY</i>	2a. DATE OF DEATH Month <i>10</i>	Day <i>-14</i>	Year <i>1968</i>	2b. HOUR <i>6 A.M.</i>	
3. SEX <i>MALE</i>	4. RACE <i>WHITE</i>	S. DATE OF BIRTH <i>4-8-86</i>	6 AGE (In years last birthday) <i>82 yrs.</i>	F. UNDER 1 YEAR MONTHS <i>82</i>	DAYS <i>0</i>	HOURS <i>0</i>	IF UNDER 24 HRS. M.H.	
7a BIRTHPLACE (State or foreign country) <i>Maryland</i>	7b CITIZEN OF WHAT COUNTRY? <i>USA</i>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9 COUNTY OF DEATH <i>Baltimore</i>					
10 CITY OR TOWN OF DEATH <i>Towson</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>STELLA Maris Hospital</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Policeman</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Police</i>					
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>	13b. COUNTY <i>Baltimore</i>	13c. CITY OR TOWN <i>Baltimore</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>4614 Northwood Drive</i>				
14. FATHER'S NAME First <i>OWEN J. MC GEENEY</i>	Middle <i></i>	Last <i></i>	15. MOTHER'S MAIDEN NAME First <i>Elizabeth YATES</i>	Middle <i></i>	Last <i></i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>Yes</i>	16b. SOCIAL SECURITY NO. <i>216-01-1275</i>	17. INFORMANT <i>Mr. Owen R.E. McGeeney,</i>	Address <i>(Same)</i>					
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>ACUTE</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>410.7</i>			DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASCVD</i> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>1201 Diabetes Mellitus</i>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1b.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22o. I certify that (I) (this hospital) attended the deceased from <i>5-7</i> , 19 <i>68</i> , to <i>10-14</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>10-14</i> 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>David Nagell</i>		DEGREE <i></i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>10-14-68</i>		
22d. PHYSICIAN'S NAME (Type) <i>J. David Nagell</i>		22e. ADDRESS <i>812 Mockingbird Lane Baltimore, Md. 21214</i>						
23a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>10/17/68.</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>New Cathedral Cemetery</i>		23d. LOCATION (City or Town) <i>Baltimore, Md.</i>	(County) <i></i>	(State) <i></i>	
24. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc. Balt. Md. 21214</i>		ADDRESS <i></i>	25a. RECEIVED BY REGISTRAR DATE <i>OCT 15 1968</i>	25b. REGISTRAR'S SIGNATURE <i>James J. Ruck</i>				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14080

Items 23 & 24 taken from burial permit 14080 kk

14090

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies pages 1, 2, and 3, and 24, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Carl	Middle William	Last McLain	2a. DATE OF DEATH Month October Year 5, 1968 p.m. 2b. HOUR 3:00 M
3. SEX male	4. RACE white	S. DATE OF BIRTH May 25, 1901	6. AGE (in years lost birthday) 67 yrs.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? U. S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore	
10. CITY OR TOWN OF DEATH Catonsville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) maintenance man	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.	13b. COUNTY	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 4719 Eastern Avenue
14. FATHER'S NAME First John	Middle	Last	15. MOTHER'S MAIDEN NAME Joda Louis	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO 213-01-4130	17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Pneumocystis pneumonia - or pulmonary</i> <i>Advanced Pulmonary Emphysema</i> <i>and Chronic Bronchitis.</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Conditions, if any, which gave</i> <i>rise to immediate cause (a),</i> <i>stating the underlying cause</i> lost. DUE TO, OR AS A CONSEQUENCE OF (c) <i>and chronic bronchitis.</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
MEDICAL CERTIFICATION 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR DRINKING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County
22a. I certify that (I) (this hospital) attended the deceased from Oct. 13, 1961, to Oct. 5, 1968, that (I) (we) last saw the deceased alive on Oct. 5, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.				
22b. SIGNATURE <i>Carl</i>	DEGREE ATTENDING PHYS	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 10/7/68	
22d. PHYSICIAN'S NAME (Type) Rafael H. Marin, M.D.	22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 11/1/68	23c. NAME OF CEMETERY OR CREMATORIAL U.ofMd. Med. School	23d. LOCATION (City or Town) Baltimore, Md.	(County) (State)
24. FUNERAL DIRECTOR Newell Funeral Home. Pikesville, Md.	ADDRESS	25a. REC'D BY REGISTRAR DATE OCT 16 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to a burial, cremation, or removal, and in any event within 72 hours after death.

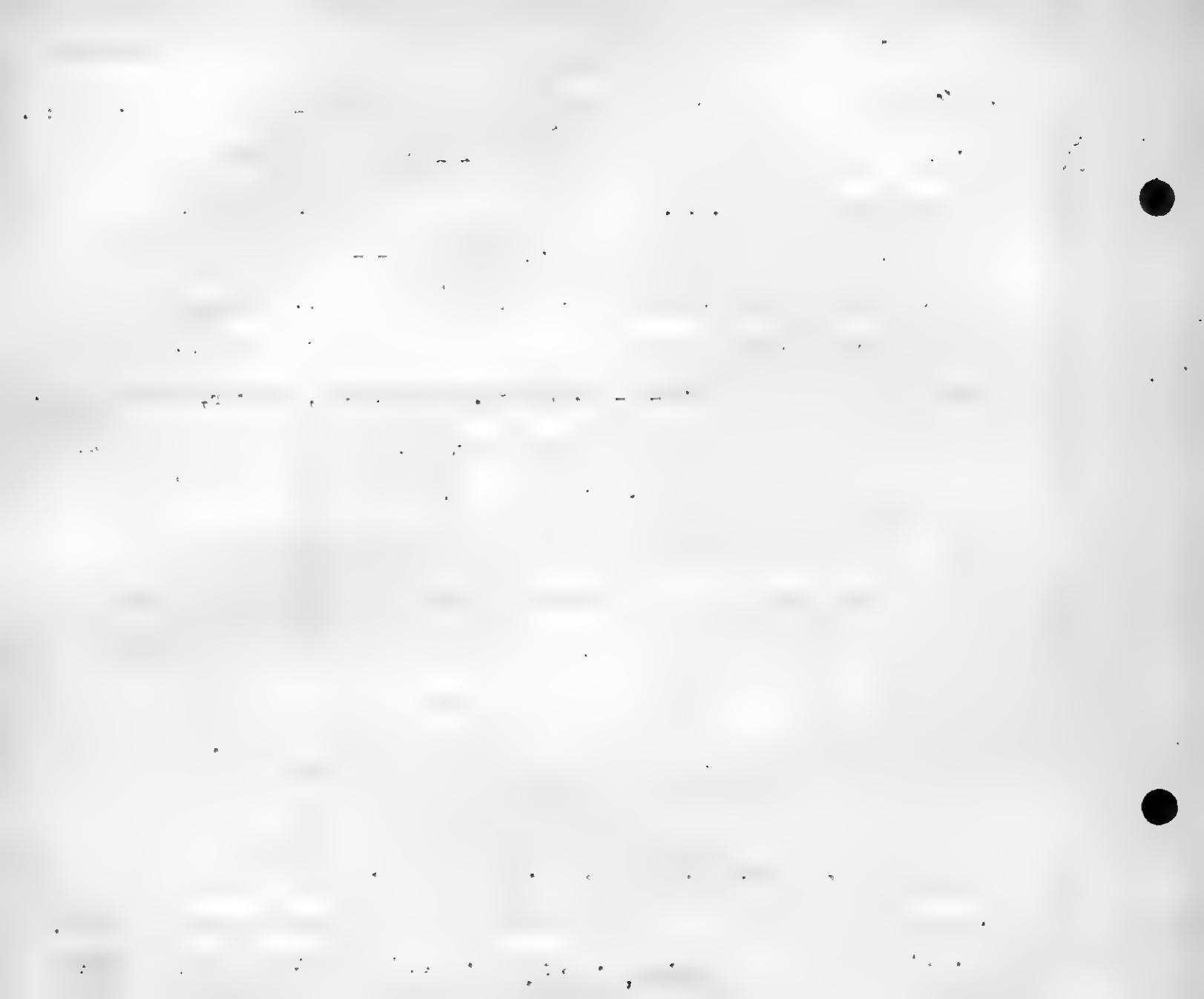
14081

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14091

1 DECEASED-NAME (Type or print)	First ALICE THROCKMORTON	Middle McLEAN	Last	2a DATE OF DEATH Month 10	Doy 25	Year 1968	2b. HOUR 9: A. M.
3 SEX FEMALE	4 RACE WHITE	S. DATE OF BIRTH 3-8-1886	6 AGE (In years last birthday) 82 YRS.	IF UNDER 24 HRS MONTHS DAYS HOURS MIN			
7a BIRTHPLACE (State or foreign country) NEW YORK CITY	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH BALTIMORE, COUNTY				
10 CITY OR TOWN OF DEATH LUTHERVILLE, MD	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) COLLEGE MANOR NURSING HOME	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND	13b COUNTY HARFORD	13c CITY OR TOWN Bel Air	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 80 BROADWAY			
14 FATHER'S NAME First JAMES McLEAN	Middle 	Last 	15. MOTHER'S MAIDEN NAME First SARA THROCKMORTON	Middle 	Last 	Address Mrs. James McLean, Bel Air, Maryland 21014	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (^{If yes give war or dates of service} No)							
16b SOCIAL SECURITY NO 219-56-5506							
17 INFORMANT 							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral vascular accident</i> 437.9 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <i>Degeneratives & cerebral arteris - Sclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH house							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or RFD No.	City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from Dec 1967 , to present 19 , that (I) (we) last saw the deceased alive on two weeks ago , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE <i>Ernest C Brown Jr MD</i>		DEGREE MD	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 10/25/68	
22d. PHYSICIAN'S NAME (Type) Dr. Ernest C. Brown, Jr.		22e ADDRESS 550 N. Broadway					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE 10/25/68	23c. NAME OF CEMETERY OR CREMATORIUM Greenmount			23d. LOCATION (City or Town) Baltimore	(County) Md.	(State)
24. FUNERAL DIRECTOR H.W.Jenkins & Sons Co.	ADDRESS 4905 York Rd. Baltimore 12, Md.	25a REC'D BY REGISTRAR OCT 25 1968			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
VR AND 30M REV 08							



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

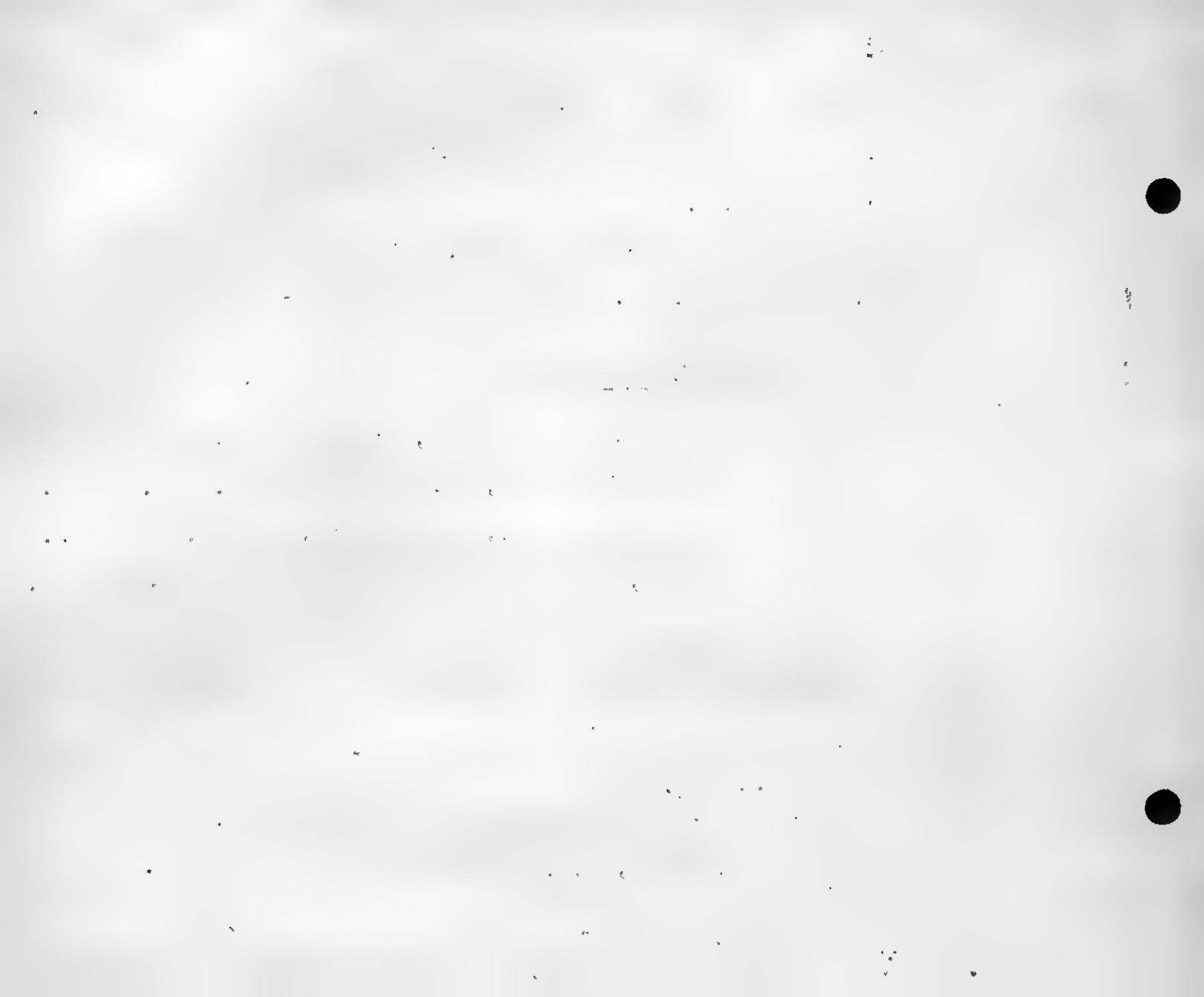
14082

14092

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR 10:45 a.m.		
			Hiram	Thomas	Meredith	October	15	1968			
3. SEX		4 RACE	5. DATE OF BIRTH			6 AGE (in years last birthday)					
male		white	May 15, 1903			65 yrs.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Baltimore		
Wash., DC		U.S.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Catonsville		SPRING GROVE STATE HOSP.			Title Lawyer						
13a. USUAL RESIDENCE (Where deceased lived, if institution) Residence before admission) STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER						
Md.		V Pr. Geo.	oxon Hill	YES <input type="checkbox"/> NO <input type="checkbox"/>	432 Maury Lane						
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.			17. INFORMANT			Address			
		577-01-3702			Records: SPRING GROVE STATE HOSPITAL						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction, acute, death,											immediate
4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 4 yrs.											DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic, cardiovascular ht. dis. 2 yrs.
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis, Generalized, senile.											2 yrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(o)											
Calcification of iliac, femoral, and popliteal arteries by x-ray.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Jan. 13, 1966, to Oct. 15, 1968, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Oct. 15, 1968, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (did not) view the body after death.											
22b. SIGNATURE <i>Anthony J. Young, M.D.</i>											22c. DATE SIGNED 3:00PM 15 Oct 68
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
Anthony J. Young, M.D.		Spring Grove State Hosp.									
23a. BURIAL CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS			23d. LOCATION (City or Town) (County) (State)				
		10/19/1967		Washington Hall			Baltimore, Prince George's Co., Md.				
24. FUNERAL DIRECTOR		ADDRESS			25a. RECD BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
<i>Wally Kelly 31-11th St. S.E.</i>											
					DATE OCT 21 1968			<i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14093

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First <i>Esther</i>	Middle <i></i>	Lost <i>Miller</i>	2d. DATE OF DEATH Month <i>Oct</i> Day <i>21</i> Year <i>1968</i>		2b. HOUR <i>12 noon</i>		
3 SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>July 24, 1878</i>		6. AGE (In years last birthday) YRS. <i>90</i>		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Baltimore</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Baltimore</i>			
10. CITY OR TOWN OF DEATH <i>Pikesville</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Professional House</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>				12b. KIND OF BUSINESS OR INDUSTRY <i>at Home</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. CITY OR TOWN COUNTY <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>Emersonian Apt. Place</i>			
14. FATHER'S NAME First <i>Louis</i>		Middle <i>Lester</i>	Lost <i>Rosalia ?</i>	15. MOTHER'S MAIDEN NAME First Middle <i>Rosalia ?</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <i>Mrs Hilda Abramson</i>		Address <i>3507 Round Hollow Road</i>			
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Insufficiency</i> APPROXIMATE INTERVAL Conditions, if any, which gave rise to immediate cause (a) <i>General Extravasation</i> BETWEEN DISCHARGE AND DEATH stating the underlying cause last. <i>old age</i> ?									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <i></i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING □ DR CONTRIBUT NG <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year PM 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY OCCURRED at home <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct</i> , 19 <i>1973</i> , to <i>Oct 15, 1968</i> , that (I) (we) last saw the deceased alive on <i>Oct 13, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Deevelel Barr</i>		22c. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		DATE SIGNED <i>October 16/68</i>					
22d. PHYSICIAN'S NAME (Type) <i>SAMUEL RECHUM</i>		22e. ADDRESS <i>MEDICAL ARTS BLDG.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Oct 16/68</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Chesapeake Cemetery</i>		23d. LOCATION (City or Town) (County) <i>Baltimore Md.</i>		(State)	
24. FUNERAL DIRECTOR <i>Sal Levenson & Sons - 6010 Reist. Rd.</i>		24c. ADDRESS <i>2nd</i>		25a. REC'D BY REG. STRR. DATE <i>OCT 21 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14094

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours.**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician. Page 4 may be retained by the hospital or attending physician. Director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First IRVIN	Middle LEVI	Last MILLER	2a. DATE OF DEATH Month OCTOBER	Day 12, 1968	Year 1968	2b. HOUR 2:17 p.m.
3. SEX MALE	4 RACE WHITE	5. DATE OF BIRTH SEPTEMBER 9, 1905			6. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE 4		
10 CITY OR TOWN OF DEATH TOWSON	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Baltimore	13c. CITY OR TOWN Overlea	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 6 West Elm Avenue 6			
14. FATHER'S NAME Brant A. Miller	15. MOTHER'S MAIDEN NAME unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 217-03-4650	17. INFORMANT Mrs Martha R. Miller 6 West Elm Avenue			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Heart Failure 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Coronary Thrombosis DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (s) (this hospital) attended the deceased from Sept. 21, 1968, to Oct. 12, 1968, that (s) (we) last saw the deceased alive on Oct. 12, 1968, and that in (s) (our) opinion death occurred on the date and hour and from the causes stated above. (s) (we) (did) (will) view the body after death.							
22b. SIGNATURE <i>Ines Cilliani</i>		DEGREE ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED Oct. 12, 1968		
22d. PHYSICIAN'S NAME (Type) Ines Cilliani MD		22e. ADDRESS 7620 York Road, Towson 4, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-16-1968	23c. NAME OF CEMETERY OR CREMATORIUM Gardens of Faith Cemetery		23d. LOCATION (City or Town) Baltimore	(County) Co.	(State) Md.
24. FUNERAL DIRECTOR Bassahn Funeral Home		ADDRESS 7401 Belair Road 21236		25a. REC'D BY REGISTRAR DATE OCT 16 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14085
14095

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. ~~Do not~~ and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

1. DECEASED NAME (Type or print)	First John K. Miller	Middle	Last	2a. DATE OF DEATH Month Oct. 19, 1968 Year	2b. HOUR 11A M			
3. SEX M	4. RACE Cauc.	S. DATE OF BIRTH May 1, 1900	6. AGE (In years last birthday) 68 yrs.	IF UNDER MONTHS	YEAR DAYS	IF UNDER 24 HRS. HOURS	MIN	
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore					
10. CITY OR TOWN OF DEATH Cockeysville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 10303 Greenside Dr.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.	13b. COUNTY Baltimore	13c. CITY OR TOWN Cockeysville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 10303 Greenside Dr.				
14. FATHER'S NAME W. Booth Miller	15. MOTHER'S MAIDEN NAME Emma B. Frederick							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. 056 05 0870	17. INFORMANT Nancy Lou Nickles, Cockeysville, Md.	Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cerebro-Vascular Disease</i> , 2 yrs 4577 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO, OR AS A CONSEQUENCE OF						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town		County	State		
22a. I certify that (I) (this hospital) attended the deceased from <u>7/22, 1968</u> , to <u>10/12, 1968</u> , that (I) (we) last saw the deceased alive on <u>10/11, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>William A. Fossbury</i>	MD., DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <u>10-14-68</u>			
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS <i>Towson, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Oct. 16, 68	23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cemetery	23d. LOCATION (City or Town) Baltimore,	(County) Baltimore, Md.	(State)			
24. FUNERAL DIRECTOR Wm. Cook-Brooks	ADDRESS Towson, Md. 21204	25a. REC'D BY REGISTRAR OCT 15 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

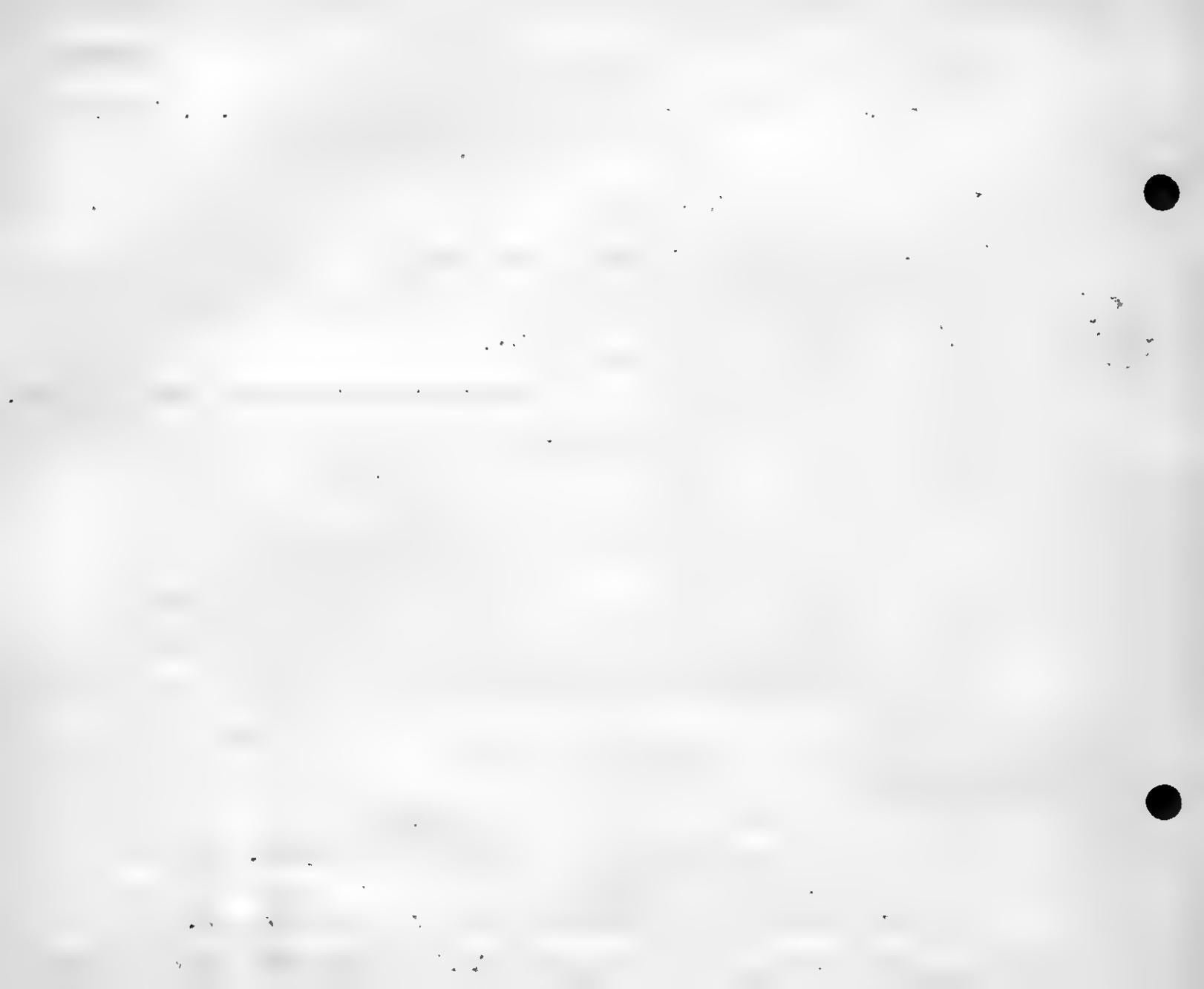
14086

14096

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be rejoined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR		
				TERESA MILLER			Oct. 3, 1968	10:30 PM		
3. SEX		4 RACE		S. DATE OF BIRTH		6. AGE (In years last birthday)				
Female		White		Nov. 24, 1885		82 yrs.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
U. S. A.		U. S. A.				Baltimore Co., Md.				
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Catonsville		Ridgeway Manor Nursing Home								
13a. USUAL RESIDENCE (Where deceased lived, if institut. on. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER			
Maryland		Baltimore City				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	2626 Maempel Lane 21223			
14 FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
Unk.					Unk.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO. ?		17. INFORMANT		Address				
No						Ridgeway Manor Nursing Home, Catonsville, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> APPROXIMATE INTERVAL 431.9 BETWEEN ONSET AND DEATH <u>1 day</u> DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
MEDICAL CERTIFICATION		19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
							YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 1968</u> to <u>Oct 1968</u> , that (I) (we) last saw the deceased alive on <u>3 Oct 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE		WILLIAM GOODMAN	DEGREE	ATTENDING PHYS	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS	<input type="checkbox"/>	22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type)		WILLIAM GOODMAN MD			22e. ADDRESS		1834 Belvoir Road			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION (City or Town)		(County)	(State)
Burial		10/9/1968		New Cathedral Cemetery			Baltimore, Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. RECEIVED BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Easton Funeral Home		Catonsville, Md.		OCT 10 1968			Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

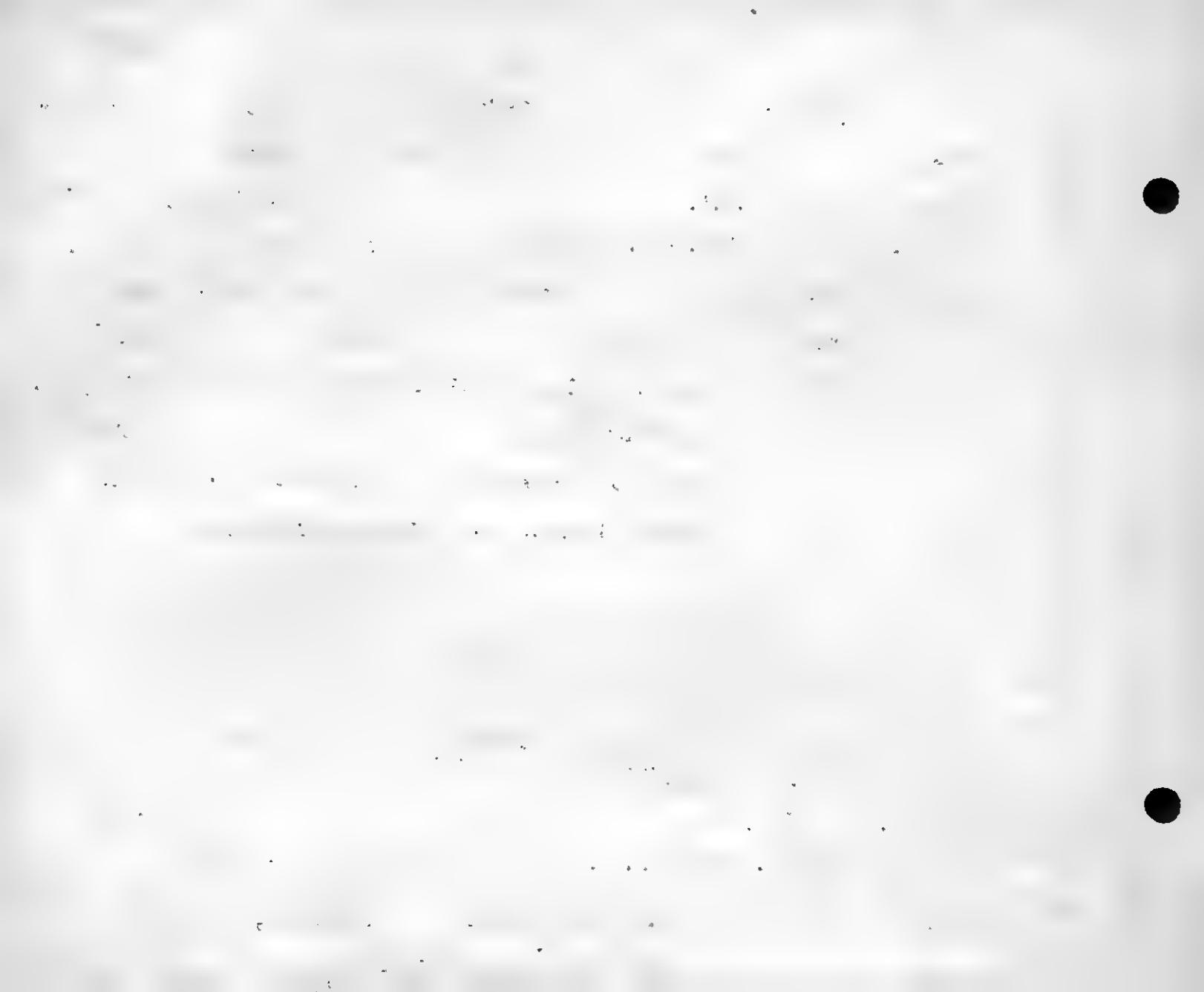
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14097

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR				
HERBERT				MILLS	Month	Day	Year				
3. SEX		4 RACE		5. DATE OF BIRTH		6 AGE (in years + birthday)		IF UNDER 1 YEAR		IF JUNIOR 24 MRS	
MALE		NEGRO		12/19/15		52		MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
MARYLAND		U.S.A.				BALTIMORE COUNTY, MARYLAND					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital <small>Street address</small>)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY					
FORT HOWARD		VET. ATM. HOSPITAL		CRANE OPERATOR		METAL CO.					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		13b. STATE		13c CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER			
MARYLAND		MARYLAND		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3100 Windsor Avenue			
14 FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last		
HERBERT				MILLS	SADIE				CHASE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <small>Yes, no, or unknown</small>		16b. SOCIAL SECURITY NO. <small>If yes, give war or dates of service</small>		17. INFORMANT		Address					
YES WW II		216 09 92 23		CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA APPROXIMATE INTERVAL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause RECENT (b) METASTATIC ADENOCARCINOMA, RIGHT LUNG AND PLEURA OLD DUE TO, OR AS A CONSEQUENCE OF (c) SURGICAL ABSENCE, LEFT KIDNEY (HYPERNEMPHROMA)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES				
21a. ACCIDENT WAS UNDERLYING <small>OR CONTRIBUTING</small> <input type="checkbox"/> CAUSE OF DEATH <small>If either, notify medical examiner</small>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED <small>(Enter nature of injury in Part I or Part 2, Item 18)</small>							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY <small>(AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)</small>		21f. LOCATION Street or R.F.D. No.		City or Town		County	State		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10/4/68 , 19 19 , to 10/15/68 , 19 19 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10/15/68 , 19 19 , and that in 1968 (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (not) view the body after death.											
22b. SIGNATURE <i>Erhard J. Bunyan</i>		DEGREE	ATTENDING PHYS	<input type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 10/15/68					
22d. PHYSICIAN'S NAME (Type)		ERHARD J. BUNYAN, M. D.		22e. ADDRESS VAH FORT HOWARD, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 10-18-68		23c. NAME OF CEMETERY OR CREMATORIAL BALTIMORE NATIONAL		23d. LOCATION (City or Town) BALTIMORE, MARYLAND		(County)		(State)	
BURIAL											
24 FUNERAL DIRECTOR		ADDRESS MORTON & DYETTE FUNERAL HOME 1701 E. LAURENS ST., BALTIMORE, MD.		25a. REC'D. BY REGISTRAR 16		25b. REGISTRAR'S SIGNATURE <i>Charles J. Gege</i>					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14083

CERTIFICATE OF DEATH

14098

1. DECEASED-NAME (Type or print)		First	Middle	Lost	2a DATE OF DEATH Month Day Year	2b HOUR 1P.M.
VIOLA		MILLS		October 15 1968		
3. SEX Female		4 RACE White		5 DATE OF BIRTH Nov. 14, 1884.		6. AGE (In years last birthday) 83 YRS
7a BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		IF UNDER 1 YEAR MONTHS DAYS
9. COUNTY OF DEATH Baltimore						IF UNMARRIED 24 HOURS HOURS MIN
10. CITY OR TOWN OF DEATH Parkville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1702 Goodview Rd.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived, if admission) STATE Md.		13c. CITY OR TOWN Parkville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1702 Goodview Rd.
14. FATHER'S NAME First John		Middle Goldwine	Lost	15. MOTHER'S MAIDEN NAME First Elizabeth		Middle Sakaites
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No		16b. SOCIAL SECURITY NO 211-18-6994		17. INFORMANT Mrs. Margaret L. Shanahan, 1702 Goodview Rd.		Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		<i>Myocardial infarction</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>less than 1 hr.</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary occlusion</i>				
		DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerotic cardiovascular disease</i>				<i>26 yrs.</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.	City or Town	County
						State
22a. I certify that (I) (this hospital) attended the deceased from <u>1958</u> , to <u>Oct - 1968</u> , that (I) (we) last saw the deceased alive on <u>Oct 15 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.						
22b. SIGNATURE <i>Dr. S. Elliott Harris</i>		MD. DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <u>10/15/68</u>
22d. PHYSICIAN'S NAME (Type) Dr. S. Elliott Harris		22e. ADDRESS 8100 Harford Rd., Balto. 34, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/18/68.	23c. NAME OF CEMETERY OR CREMATORIAL Moreland Mem. Cemetery		23d. LOCATION (City or Town) Baltimore, Md.	(County) (State)
24. FUNERAL DIRECTOR Leonard J. Ruck Inc.		ADDRESS 5305 Harford Rd.	25a. REC'D BY REGISTRAR OCT 16 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
2 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

Item 10 Film G406
10/30/68 kk
16083

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14099

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)	First Anna	Middle	Last Mitchell	2a. DATE OF DEATH Oct Month 12 PM 1968	2b. HOUR M	
3. SEX Female	4 RACE White	5 DATE OF BIRTH 7-13-1887	6 AGE (in years last birthday) 81 yrs.	F UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Pa.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore			
10 CITY OR TOWN OF DEATH Baltimore Co.	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 6821 Alter St.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	12b. KIND OF BUSINESS OR INDUSTRY 			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.	13b. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 1821 Alter St.			
14 FATHER'S NAME Hector	15 MOTHER'S Maiden NAME First Middle Last Elizabeth Kuehn	Address				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO 	17 INFORMANT 	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arterio-sclerosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. 4409 (b) DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 4501						
19a. DATE OF OPERATION 	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 			
MEDICAL CERTIFICATION 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) 			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) 	21f. LOCATION Street or R.F.D. No. 	City or Town 	County 	State 	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Nathan B. Herman, M.D.	22c. DATE SIGNED 16/12/68					
22d. PHYSICIAN'S NAME (Type) Nathan B. Herman	22e. ADDRESS 55-10 Island Ave.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/15/68	23c. NAME OF CEMETERY OR CREMATORIAL Rummel Ruth Cem.	23d. LOCATION (City or Town) Paint Township, Pa.	(County) 	(State) 	
24. FUNERAL DIRECTOR Wm. J. Tickner & Sons Balt., Md.	ADDRESS 	25a. REC'D BY REGISTRAR 	25b. REC'D BY REGISTRAR OCT 28 1968	26b. REC'D BY REGISTRAR Charles Judge		



FOR STATE
HEALTH DEPT.



PMA: Page
of

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil on Item 10. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm files. 5 may be retained for your files.

10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

14100

1 DECEASED-NAME (Type or Print)		First	Middle	Lost	2a DATE KNOWN OF ESTI. DEATH MATED	X Month 10-5-68 Year 19	2b HOUR 9a M
3 SEX male	4 RACE white	5 DATE OF BIRTH July 4 1895	6 AGE (In years last birthday) 79	7 IF CHILD MONTHS YRS	8 IF UNDER 24 HRS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD Mo 10-5-68 Day Year 19	2d HOUR 9a m
7d BIRTHPLACE (State or foreign country) Lithuania		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Balto.	
10 CITY OR TOWN OF DEATH Catonsville		11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street name) Spring Grove State Hosp		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) tailor		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceasedived, if institution: Residence before admission) Md.		13b COUNTY		13c CITY OR TOWN Balto.	13d INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 34 S. Carey St.	
14 FATHER'S NAME John Mikalanakas		15 MOTHER'S MAIDEN NAME Ona Chiancus					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO 215-16-9053A		17 INFORMANT Records; Spring Grove esp.		ADDRESS	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Uremia				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
2509 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost		DUE TO, OR AS A CONSEQUENCE OF (b) Nephrosclerosis					
		DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus				25 years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 260x Fracture hip							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day Year HOUR A.M. P.M. 9-25-68		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) fall			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street factory, office building, etc.) Spring Grove Hosp		21f LOCATION Street or R.F.D. No City or Town Catonsville Md.		County Balto. Md.	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>J. Nelson McKay</i>		MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED 10-5-68	
EXAMINER'S NAME (Type) J. Nelson McKay ADDRESS (Street, city, town, or county)							
23a BURIAL CREMATION REMOVAL (Specify) Burial		23b DATE Oct 10 1968		23c NAME OF CEMETERY OR CREMATORIAL new cathedral		23d LOCATION City or Town (County) (State) old French Road Balto. Md.	
24 FUNERAL DIRECTOR Krause Funeral Home		ADDRESS 1216 S Charles St		25a REC'D BY REGISTRAR Oct 14 1968		25b REGISTRAR SIGNATURE Judge	
VR A15ME (5) TOM REV 1/68							



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14101

16091

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First Mable	Middle M	Last Mitter	20. DATE OF DEATH Month October	Day 10	Year 1968	2b HOUR 6 08				
3 SEX female	4 RACE white	5. DATE OF BIRTH Feb. 5, 1896			6. AGE (In years last birthday) 62	IF UNDER 1 YEAR MONTHS X	IF UNDER 24 HRS DAYS XX	IF UNDER 24 HRS HOURS XX	MIN. XX			
7a. BIRTHPLACE (State or foreign country) West Virginia	7b. CITIZEN OF WHAT COUNTRY? U S A	B MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore									
10. CITY OR TOWN OF DEATH Reisterstown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cent Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife			12b. KIND OF BUSINESS OR INDUSTRY at home					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY A	13c. CITY OR TOWN Linthicum	13d. INSIDE CITY LIMITS? YES X NO	13e. STREET AND NUMBER None								
14. FATHER'S NAME First Ellis	Middle Menear	Last	15. MOTHER'S MAIDEN NAME First Sarah Poe	Middle XXXXXXXXXX	Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO 236-32-6823	17. INFORMANT Mildred Mitter, Linthicum, Md	Address									
18. CAUSE OF DEATH (Enter only one cause per line for (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Lymphoma, lymphoblastic DUE TO, OR AS A CONSEQUENCE OF 2049 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 years				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 10110												
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.			City or Town	County	State				
22a. I certify that (I) (this hospital) attended the deceased from Aug. 7, 1968 , to Oct. 10, 1968 , that (I) (we) last saw the deceased alive on Oct. 10, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 10-10-68		
22b. SIGNATURE C E McWilliams MD		22d. PHYSICIAN'S NAME (Type)	DEGREE MD	ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/13/68	23c. NAME OF CEMETERY OR CREMATORIAL Evansville			23d. LOCATION (City or Town) Newburg	(County) W. Va.	(State)				
24. FUNERAL DIRECTOR John R. Slack		ADDRESS Ellicott City Md.				25a. RECD BY REGISTRAR DATE OCT 15 1968	25b. REGISTRAR'S SIGNATURE Charles Judge					



FOR STATE
HEALTH DEPT.

any delay is
pending in
item 1, 2, or 3
in filing
with the State Department of
Health

Health prior to burial, cremation, or removal, and in any event within 72 hours after death

5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Chief Medical Examiner's Office along with form PM3.

Health prior to burial, cremation, or removal, and in any event within 72 hours after death

5 may be retained for your files.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pages 1, 2, or 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3.

Health prior to burial, cremation, or removal, and in any event within 72 hours after death

15092

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14102

1. DECEASED NAME (Type or Print)			First MILDRED	Middle REGINA	Last MOHR	To DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	Month 19	Day M	Year 1968	2b HOUR 2d HOUR 8:15 P.M.		
3 SEX Female	4 RACE White	5 DATE OF BIRTH 2-28-1917	6 AGE (in years last birthday) 51 YRS	7 IF UNDER 1 YEAR MONTHS 0	8 IF UNDER 24 HRS. DAYS 0	9 HOURS 0	10 DATE PRONOUNCED DEAD Month October	Day 16	Year 1968	11 COUNTY OF DEATH BALTIMORE		
7a BIRTHPLACE (State or foreign country) Baltimore		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		12c USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Clerk					12b KIND OF BUSINESS OR INDUSTRY A&P Stores	
10. CITY OR TOWN OF DEATH Fulterton (Rural)			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 4244 Thorncliff			12a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.			13c CITY OR TOWN Baltimore		13d INSIDE CTY LIMITS? Fullerton	13e STREET AND NUMBER 4244 Thorncliff Rd 21236
14. FATHER'S NAME First John			Middle Thomas	Last Kearney	15. MOTHER'S MAIDEN NAME First Catherine A.			Middle Shelly	16. SOCIAL SECURITY NO. 213-03-6315		17. INFORMANT Mr. Edward F. Greives Rt#2 Finksburg, Md	ADDRESS 21048
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (a) Overdose of barbiturate 7500 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21b TIME OF INJURY Month, Day, Year ? HOUR A.M. P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Took overdose of barbiturates						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home			21f LOCATION Street or R.F.D. No 4244 Thorncliff			City or Town Baltimore	County Md.		
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>Charles S. Springate</i>			EXAMINER'S NAME (Type) Charles S. Springate, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D.	22b. DATE SIGNED October 17, 1968		
DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county) Parkville Balto. Co Md.												
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE 10-19-1968			23c NAME OF CEMETERY OR CREMATORIAL Parkwood Cemetery			23d LOCATION (City or Town) (County) (State) Parkville Balto. Co Md.			
24. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Road 21236			ADDRESS			25a REC'D BY REGISTRAR OCT 22 1968			25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
VR A15M 10M REV 168												



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14103

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14093

1 DECEASED-NAME (Type or print)	First Clyde R. Morrow	Middle	Lost	2a DATE OF DEATH 10 Month 22 Day 68 Year	2b HOUR 10 M
3 SEX Male	4. RACE White	S DATE OF BIRTH May 24, 1885	6 AGE (in years last birthday) 83 YRS	F UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (State or foreign country) New York	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Balto.		
10 CITY OR TOWN OF DEATH Catonsville	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) house of the Pines	12a USJA. OCCUPATION (Kind of work done during most of working life, even if retired) Retired	12b KIND OF BUSINESS OR INDUSTRY Md.		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.	13b COUNTY Balto	13c CITY OR TOWN Balto	13d INSIDE CTY LIM IS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 5514 Gwynn Oak Ave., 21215	
14 FATHER'S NAME First George E. Morrow	Middle	Last	15 MOTHER'S MAIDEN NAME First Ida	Middle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No	16b. SOCIAL SECURITY NO. 220-05-1595A	17. INFORMANT Mr. Miles Morrow, 670 Cross Country Blvd.	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (o) Acute Myocardial Infarction Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. 4129			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hr		
(b) Chronic Arteriosclerotic Cardio-Vasc. Disease			15 yrs		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4221 Acute Onset Onset					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from 10-18 , 19 68 , to 10-22 , 19 68 , that (I) (we) last saw the deceased alive on 10-22 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (had) (did not) view the body after death.					
22b. SIGNATURE Wilmer K. Gallager, Jr. M.D.			DEGREE ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22c. DATE SIGNED 10-24-68			22d. ADDRESS 6209 Frederick Road		
23a. BURIAL, CREMATION, REMOVAL (Specify) 10 Burial	23b. DATE 10/24/68	23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cemetery	23d. LOCATION (City or Town) Baltimore, Maryland	(County)	(State)
24. FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave., 21229	ADDRESS	25a. REG'D BY REGISTRAR OCT 25 1968	25b. BAR'S CHART Charles Judge		
VR A1 45M - 1X69					

126

127

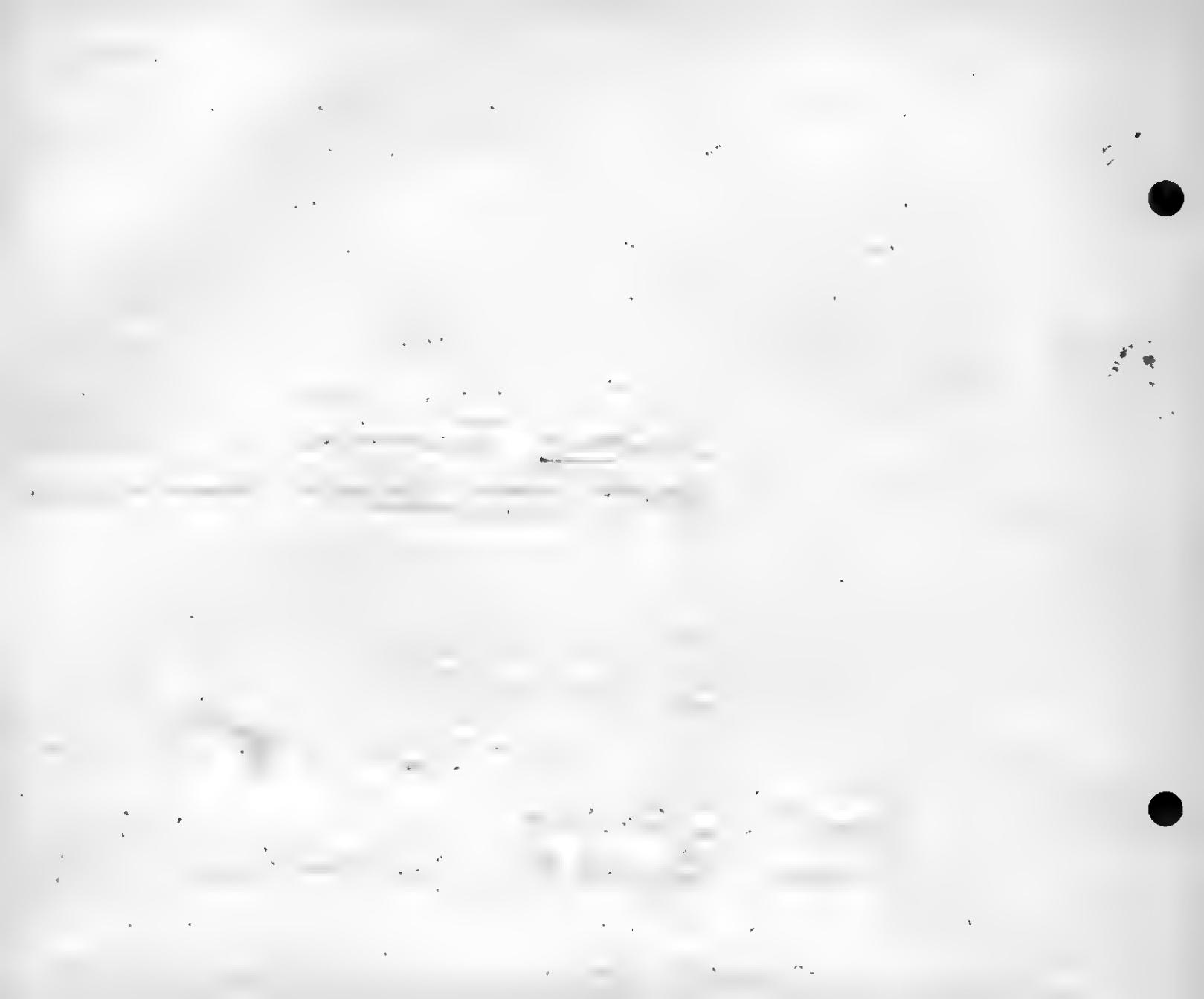
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and may, event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and may, event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First <i>Mary</i>	Middle <i>E.</i>	Last <i>Mosner</i>	2a. DATE OF DEATH Oct. 18, 1968	2b. HOUR M
3 SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>October 29, 1884</i>		6. AGE (In years last birthday) <i>83</i>	IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS. HOURS <i>0</i>
7a. BIRTHPLACE (State or foreign country) <i>Balto. Co.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Baltimore</i>	
10. CITY OR TOWN OF DEATH <i>Reisterstown</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>109 Glyndon Drive</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Reisterstown</i>	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>109 Glyndon Drive</i>
14. FATHER'S NAME First <i>Randolph</i>		Middle <i>Slade</i>	Last	15. MOTHER'S MAIDEN NAME First <i>Alverta</i>		Middle <i>Morrison</i> Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <i>No, no, or unknown</i>		16b. SOCIAL SECURITY NO. <i>213-01-1982</i>		17. INFORMANT <i>Mrs. J. Edward Hewes</i>	Address <i>Reisterstown, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		<i>Colonary Thrombosis</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>several days</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DE TO, OR AS A CONSEQUENCE OF <i>Hyper tensioe disease</i>				
(b)		DE TO, OR AS A CONSEQUENCE OF <i>cardio-vascular</i>				
(c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County <i>Reisterstown</i>
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct. 1 - 1964</i> , to <i>Oct. 18, 1968</i> , that (I) (we) last saw the deceased alive on <i>Oct. 18, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>James O. Daffell MD</i>		DEGREE <i>MD</i>	ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>Oct. 19, 1968</i>		
22d. PHYSICIAN'S NAME (Type) <i>James O. Daffell MD</i>		22e. ADDRESS <i>Reisterstown, Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23d. DATE <i>Oct. 21, 1968</i>	23b. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Gilead</i>	23d. LOCATION (City or Town) <i>Baltimore Co., Md.</i>	(County) <i>Md.</i>	(State)
24. FUNERAL DIRECTOR <i>J. F. Eline & Sons Reisterstown, Md.</i>		ADDRESS		25a. REC'D. BY REGISTRAR <i>OCT 22 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, file the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #23a, b, Fi. 12, 1968, Rm. 3406 11/21/68 km

CERTIFICATE OF DEATH

15639

1 DECEASED NAME (Type) 16095 Lisa	First Ann	Middle Mrak	Last	2a DATE OF DEATH Month 10	Day 26	Year 1968	2b HOUR AM 11:30
3 SEX Female	4 RACE White	5. DATE OF BIRTH 10/26/68			6 AGE (In years lost birthday) YRS. 25	IF UNDER 1 YEAR MONTHS 2	IF UNDER 24 HRS HOURS 35
7a BIRTHPLACE (State or foreign country) Maryland	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH Baltimore			Md
10. CITY OR TOWN OF DEATH Towson	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital			12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) N/A			12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased resided, if institution Reside before admission) STATE Maryland	13b COUNTY Baltimore	13c CTY OR TOWN Reisterstown	13d INSIDE CITY LHM TS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 29 Chestnut Hill Lane			
14 FATHER'S NAME Robert	First Mrak	Middle	Last	15 MOTHER'S MAIDEN NAME Dianne	First B.	Middle	Last Bull
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	16b. SOCIAL SECURITY NO	17 INFORMANT			Address		
18 CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 777 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF last (c) DUE TO, OR AS A CONSEQUENCE OF							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <small>FILE either, notify medical examiner</small>	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat wh le <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10/26/68 , to 10/26/68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10/26/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE <i>Young Ho Yu, M.D.</i>	REBEE	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c DATE SIGNED 10/26/68		
22d. PHYSICIAN'S NAME (Type) Young Ho Yu, M.D.	22e ADDRESS 7620 York Rd., Towson, Md. 21204						
23a BURIAL, CREMATION, REMOVAL (Specify) Removal	23b DATE 11/19/FR	23c NAME OF CEMETERY OR CREMATORIAL Anatomy Board of Maryland			23d LOCATION (City or Town) Baltimore, Maryland	(County)	(State)
24 FUNERAL DIRECTOR	ADDRESS			25a. RECD BY REG STRR DATE NOV 21 1968	25b. REGISTRAR'S SIGNATURE <i>J. Young, Jr., M.D.</i>		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PHM. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14096 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14105

1. DECEASED-NAME (Type or Print)			First	Middle	Last	7	2a. DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b. HOU.R 10 5 1688:40pm
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	7 IF UNDER 1 YEAR MONTHS	8 IF UNDER 24 HRS DAYS	9	2c. DATE PRONOUNCED DEAD Month	Day	Year	2d. HOUR October 5 1978 8:40pm	
Male	White	Sept. 14, 1968	3 wks yrs	-	-						
7a. BIRTHPLACE (State or Foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Balto.					
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institut ion) Residence before admission) STATE Md.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Hollen 702 xxxxxx Rd.					
14. FATHER'S NAME First Kent Middle F. Last Muhly		15. MOTHER'S MAIDEN NAME Carelyn						Last Conkling			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) None		17. INFORMANT Mr. Kent F. Muhly		ADDRESS (Same)					
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Interstitial pneumonitis (SDII)</u> DUE TO, OR AS A CONSEQUENCE OF 484X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7130											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Edward F. Wilson, M.D.</u>											
22b. DATE SIGNED October 6, 1968											
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.											
23a. BURIAL, CREMAT. ON, REMOVAL (Specify) Burial			23b. DATE 10/8/68.			23c. NAME OF CEMETERY OR CREMATORIAL Holy Redeemer Cemetery			23d. LOCAT. ON (City or Town) Baltimore, Md. (County) (State)		
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214			ADDRESS			25a. REC'D BY REGISTRAR OCT 8 1968			25b. REC'D STAR'S SIGNATURE <u>Charles Judge</u>		
VR A15ME 51 10M REV 1/68											



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14106

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First EDNA	Middle W.	Lost	20. DATE OF DEATH Month Oct.	21. HOUR Year 31 68	2b. HOUR 4:45 AM	
3. SEX Female	4. RACE white	S. DATE OF BIRTH 11/15/1899	6 AGE (in years lost birthday) 68 yrs.	IF UNDER 1 YEAR MONTHS 6			
7a BIRTHPLACE (State or foreign country) Cleveland	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Baltimore	IF UNDER 24 HRS. HOURS 4 1/2			
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Chesapeake Manor	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Lena Gutnick	12b. KIND OF BUSINESS OR INDUSTRY Gutnick E.C.H.				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.	13b. COUNTY Baltimore	13c. CITY OR TOWN Timonium	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 306 W. Timonium Rd.			
14. FATHER'S NAME First Fred W. Amtsberg	Middle 	Lost	15. MOTHER'S MAIDEN NAME First Lena Gutnick	Middle Gutnick E.C.H.	Lost		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. 273 01 6848	17. INFORMANT 850 Hospital Records.	Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) NANITION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause GENERALIZED LYMPHOBLASTOMA 11 YEARS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 2021							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (his hospital) attended the deceased from 2/7 , 19 62 , to 10/31 , 19 68 , that (I) (we) last saw the deceased alive on 10/30 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Donald L. Somerville, M.D.		DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 10/31/68	
22d. PHYSICIAN'S NAME (Type) DONALD L. SOMERVILLE, M.D.		22e. ADDRESS 25 W. PA-AVE. TOWSON, MD 21204					
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov. 4, 68	23c. NAME OF CEMETERY OR CREMATORIUM West Park		23d. LOCATION (City or Town) Cleveland, Ohio	(County)	(State)
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Towson, Md. 21204		ADDRESS	25a. RECD BY REGISTRAR DATE NOV 1 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

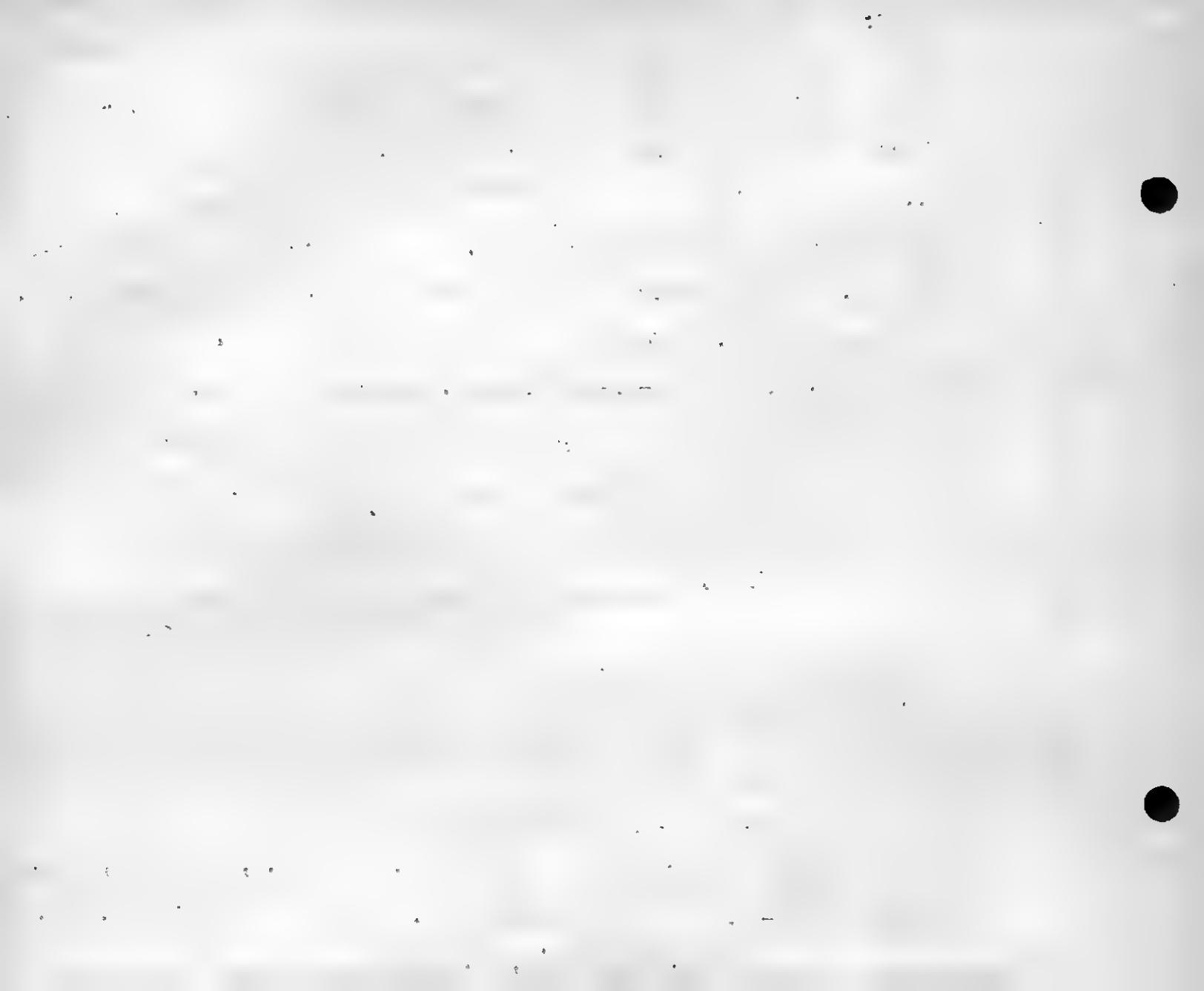
CERTIFICATE OF DEATH

14107

1 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

2 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, Page 4 may be retained by the hospital or attending physician. Then ~~please~~ remove carbon papers. Pages 1 and 2 should be detached for use as the burial-transit permit. Then ~~please~~ remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)	First THOMAS	Middle LEO	Last MURDOCK	2a. DATE OF DEATH October 6, 1968.	2b. HOUR 12:30 PM							
3. SEX Male	4. RACE White	S. DATE OF BIRTH October 31, 1891	6. AGE (in years last birthday) 76 yrs.	IF UNDER MONTHS	YEAR DAYS	IF UNDER 24 HRS. HOURS	MIN.					
7a. BIRTHPLACE (State or foreign country) Balto., Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore	Md.								
10. CITY OR TOWN OF DEATH Bowleys Quarters	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Box # 127 Bengies Rd.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired	12b. KIND OF BUSINESS OR INDUSTRY Storekeeper									
13a. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) STATE Md.	13b. COUNTY Baltimore	13c. CITY OR TOWN Bowleys Quarters	13d. INSIDE CITY LIMITS? NO <input type="checkbox"/>	13e. STREET AND NUMBER Box # 127 Bengies Rd. #26.								
14. FATHER'S NAME James	First E.	Middle Murdock	15. MOTHER'S MAIDEN NAME Dora	Middle E.	Last Ceeke							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown Yes	16b. SOCIAL SECURITY NO W.W.I	17. INFORMANT Henry S. Murdock	Address Same.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)				Acute Myocardial Infarction					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10-6-68			
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic C.V. Disease									4-5-67			
DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus									4-5-67			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED None		20a. AUTOPSY? YES <input type="checkbox"/> No <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? None							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner.)		21b. TIME OF INJURY HOUR A.M. Month Day P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) None		21d. LOCATION Street or R.F.D. No. City or Town County State						
21d. INJURY OCCURRED While <input type="checkbox"/> at home <input checked="" type="checkbox"/> at work at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.) None		21f. LOCATION Street or R.F.D. No. None								
22a. I certify that (I) (this hospital) attended the deceased from 4-5-67, 19, to 10-6-68, that (I) (we) last saw the deceased alive on 10-6-1968, and that in (my) <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.												
22b. SIGNATURE E.G. Schimunek MD		ATTENDING PHYS.		<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 10-7-68						
22d. PHYSICIAN'S NAME (Type) EMANUEL A. SCHIMUNEK		22e. ADDRESS 842 S. East Ave., Baltimore, 21224, Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-9-68.		23c. NAME OF CEMETERY OR CREMATORIAL New Cathedral Cem.		23d. LOCATION (City or Town) 4300 Old Frederick Rd., Md.		(County)			(State)	
24. FUNERAL DIRECTOR Charles S. Geier		ADDRESS 6224 Eastern Ave. Baltimore, 21224, Md.		25a. RECD BY REGISTRAR DATE OCT 8 1968		25b. REGISTRAR'S SIGNATURE Charles Geier						



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14099

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14108

1. DECEASED-NAME (Type or print)	First RICHARD	Middle C.	Last O'CONNELL	2a. DATE OF DEATH Month OCTOBER	Day 19	Year 1968	2b. HOUR 7:10 M	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH DEC. 22, 1891		6. AGE (In years last birthday) 76	YRS	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH TOWSON XX, BALTIMORE					
10. CITY OR TOWN OF DEATH TOWSON 4	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired-Supervisor				
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE MARYLAND	13b. COUNTY BALTIMORE	13c. CITY OR TOWN TOWSON	13d. INSIDE CITY LIMITS? YES	13e. STREET AND NUMBER 238 Burke Ave.	12b. KIND OF BUSINESS OR INDUSTRY Transportation			
14. FATHER'S NAME First Charles T. O'Connell	Middle	Last	15. MOTHER'S MAIDEN NAME First Frances	Middle	Last B.	Address Murphy		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes WWI & WWII	16b. SOCIAL SECURITY NO. 214-40-5536	17. INFORMANT Mrs. Ona B. O'Connell	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (Same.)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration of gastric contents</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Intestinal obstruction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>carcinoma of colon with distant metastasis.</u>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
MEDICAL CERTIFICATION <i>10/16/68</i>	19a. DATE OF OPERATION 10/16/68	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal obstruction	20a. AUTOPSY? YES	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
	21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State			
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from OCT. 16, 1968 , to OCT 19, 1968 , that <input type="checkbox"/> (we) last saw the deceased alive on OCTOBER 19, 1968 , and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> (we) (did) <input type="checkbox"/> (did not) view the body after death.								
22b. SIGNATURE <i>Christina Feliciano, M.D.</i>	DEGREE M.D.	ATTENDING PHYS. <input type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED OCT. 19, 1968			
22d. PHYSICIAN'S NAME (Type) Christina Feliciano, M. D.	22e. ADDRESS 7620 YORK RD. TOWSON 4, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/22/68	23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National	23d. LOCATION (City or Town) Baltimore	(County) Md.				
24. FUNERAL DIRECTOR H.W.Jenkins & Sons Co.	ADDRESS 14905 York Road Balto. 12, Md.	25a. REC'D BY REGISTRAR DAT OCT 21 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

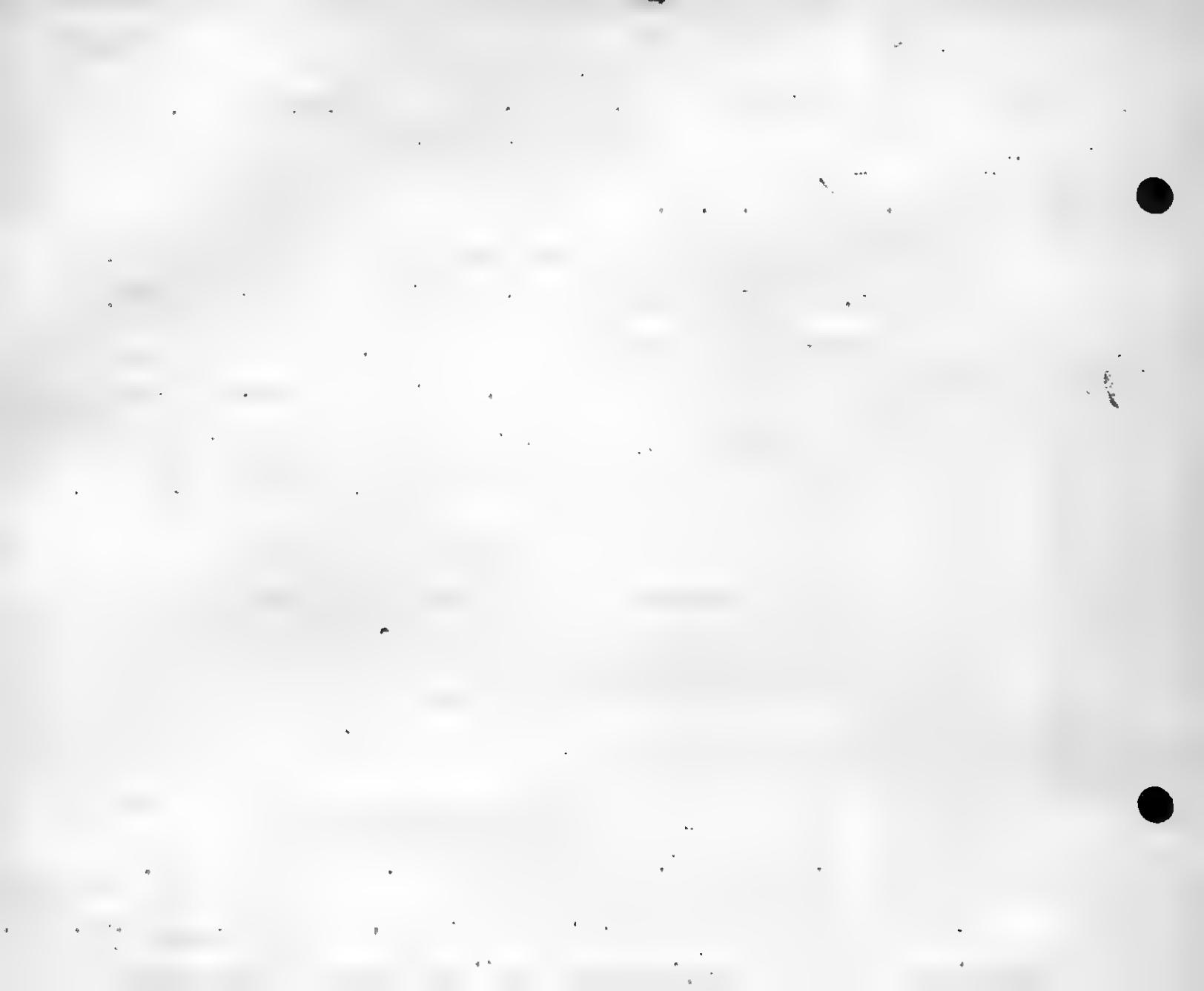
CERTIFICATE OF DEATH

14109

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 14100	First Wallace	Middle W.	Last Oles	2a. DATE OF DEATH Month October	Day 5, 1968	2b. HOUR M	
3 SEX M	4 RACE W	5. DATE OF BIRTH 7/23/1905		6. AGE (in years last birthday) 63		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Conn.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore			
10. CITY OR TOWN OF DEATH Ruxton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1608 Ruxton Road		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired - Sales		12b. KIND OF BUSINESS OR INDUSTRY Envelope	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Baltimore	13c. CITY OR TOWN Ruxton	13d. INSIDE CITY LIMIT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1608 Ruxton Road			
14. FATHER'S NAME Burdette	Middle Oles	Last	15. MOTHER'S MAIDEN NAME V.	First Mrs. Natalie Webb Oles	Middle (Same)	Address	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown Yes	16b. SOCIAL SECURITY NO. WWII	17. INFORMANT V.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 4.1.7		DUE TO, OR AS A CONSEQUENCE OF (b). Arteriosclerotic heart disease		DUE TO, OR AS A CONSEQUENCE OF (c). Years			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. MEDICAL CERTIFICATION DATE		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (1) (This hospital) attended the deceased from Jan. 19, 1968, to Oct. 8, 1968, that (2) (we) lost saw the deceased alive on Sept. 19, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE R.K. Gundry		DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 10-7-68		
22d. PHYSICIAN'S NAME (Type) Dr. Richard K. Gundry		22e. ADDRESS 2 W. University Pkwy.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/7/68	23c. NAME OF CEMETERY OR CREMATORIUM Moreland Memorial Pk.		23d. LOCATION (City or Town) Parkville		(County) Balto. Co., Md. (State)
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Rd. Balto. Md.	25a. RECEIVED BY REGISTRAR OCT 8 1968		25b. REGISTRAR'S SIGNATURE James J. Jenkins		



FOR STATE
HEALTH DEPT.

any delay is
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMJ. Page
5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of
Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14101 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14110

1 DECEASED NAME (Type or Print)	First <i>Ronald</i>	Middle <i>C.</i>	Last <i>Owings</i>	2a. DATE KNOWN OF ESTI. DEATH MATED <input checked="" type="checkbox"/>	Month <i>Oct.</i>	Day <i>3, 68</i>	Year <i>19</i>	2b. HOUR <i>4:50 P.M.</i>					
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>March 14, 1949</i>	6. AGE (In years last birthday) <i>79 yrs</i>	IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS DAYS <i>0</i>	HOURS <i>0</i>	MIN. <i>0</i>	2c. DATE PRONOUNCED DEAD Month <i>Oct.</i>	Day <i>3, 68</i>	Year <i>19</i>	2d. HOUR <i>4:50 P.M.</i>		
7a. BIRTHPLACE (State or foreign country) <i>Balto. City</i>	7b. CITIZEN OF WHAT COUNTRY? <i>US<i>r</i></i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Baltimore</i>										
10. CITY OR TOWN OF DEATH <i>Reisterstown</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>117 1st Ave.</i>			12a. USUAL OCCUPATION (Kind of work done or name of employer if not in hospital) <i>Maryland Paper Cup Company</i>	12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>Balto.</i>	13c. CITY OR TOWN <i>Reisterstown</i>	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>117 1st. Ave.</i>									
14. FATHER'S NAME First <i>Clinton</i>	Middle <i>R.</i>	Last <i>Owings</i>	15. MOTHER'S MAIDEN NAME First <i>Delores</i>	Middle <i>E.</i>	Last <i>Mitchell</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no) <i>No</i>	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <i>218-54-2706</i>	17. INFORMANT <i>Mr. Clinton R. Owings Reisterstown, Md.</i>	ADDRESS										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Gunshot wound head</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>instant</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year Month <i>9</i> Hour A.M. <i>to 3</i> P.M. <i>Oct. 3 68</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>self inflicted</i>									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, off ce building, etc.) <i>Home</i>		21f. LOCATION Street or R.F.D. No. <i>117 1st Ave.</i>		City or Town <i>Reisterstown, Balto., Md.</i>		County <i>Balto.</i>		State <i>Md.</i>			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> X, Inquiry <input type="checkbox"/> X, and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> X, Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
ACTUAL SIGNATURE <i>D. D. Caples</i>								M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <i>10-4-68</i>			
EXAMINER'S NAME (Type) <i>D. D. Caples, M. D.</i>								DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>10/5/68</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>All Saints Cemetery</i>		23d. LOCATION (City or Town) <i>Reisterstown, Md.</i>		(County) <i></i>		(State) <i></i>			
24. FUNERAL DIRECTOR <i>J. F. Eline & Sons Reisterstown, Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR DATE <i>OCT 7 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 13 filmed 7/1/68

CERTIFICATE OF DEATH

14102

14111

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be received within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First MIDDLE LAST	2a. DATE OF DEATH Month Day Year	2b. HOUR IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF OVER 24 HRS Md	
MARY	Marcella PADIAN	10 12 68	11:20A.M	
3. SEX <input checked="" type="checkbox"/> F	4. RACE <input checked="" type="checkbox"/> W	5. DATE OF BIRTH 6/12/1880	6. AGE (in years last birthday) 58 YRS.	
7a. BIRTHPLACE (State or foreign country) <input checked="" type="checkbox"/> BALTIMORE	7b. CITIZEN OF WHAT COUNTRY? <input checked="" type="checkbox"/> U.S.A	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE	
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Stella Maris Hospice	12a. USUAL OCCUPATION (Kind of work done during most of work no life, even if retired) Housewife	12b. KIND OF BUSINESS OR INDUSTRY None	
13a. USUAL RESIDENCE (Where deceased lived, if institutional residence before admission) STATE MD.	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 715 Arlington Avenue	
14. FATHER'S NAME First Middle Last DANIEL J Fielding	15. MOTHER'S MAIDEN NAME LAURA		16. ADDRESS Towson MD.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO	16b. SOCIAL SECURITY NO. None	17. INFORMANT Stella Maris Hospice Inc.	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH clerical	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bacterial CVA</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c)				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Carcinoma of the breast</u>				
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No	City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from <u>7-26-68</u> , to <u>10-12-68</u> , that (I) (we) last saw the deceased alive on <u>10-11-68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <u>J. David Nagel</u>		DEGREE ATTENDING PHYS.	MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 10-12-68
22d. PHYSICIAN'S NAME (Type) J. David Nagel, M.D.		22e. ADDRESS 812 Mockingbird Lane		
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE Oct. 15, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Marie Cemetery	23d. LOCATION (City or Town) Towson, Maryland	(County) (State)
24. FUNERAL DIRECTOR John Burns & Sons	ADDRESS 6100 York Rd.	25a. REC'D. BY REGISTRAR OCT 18 1968	25b. REGISTRAR'S SIGNATURE Charles Judge	



14103

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 5 & 6 Filed 10/30/68 kk CERTIFICATE OF DEATH

14112

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Florence	Middle I.	Last Page	2a. DATE OF DEATH Month Oct 21	Year 68	2b. HOUR 4:04 PM	
3. SEX Female	4 RACE White	5. DATE OF BIRTH 5-30-96 1895		6. AGE (in years last birthday) 73 7 MRS	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) W. Va	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore,				
10. CITY OR TOWN OF DEATH Landallsown	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Balto Gen 3401 Old Court Rd.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) House wife	12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.	13b. COUNTY Balto	13c. CITY OR TOWN Jewin S. Md.	13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 2x233 Lyons Mill Rd.			
14 FATHER'S NAME James Whittington	First Middle Last	15. MOTHER'S MAIDEN NAME First ?					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No or unknown)	16b. SOCIAL SECURITY NO 220-03-9185 B	17 INFORMANT James N. Page	Address 3506 St. James Rd. Balto. 07				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Bronchopneumonia</u> 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). (b) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic Heart Disease</u>							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4129							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING (if either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING ETC)	21f LOCATION Street or R.F.D. No	City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>10/19/68</u> , to <u>10/21/68</u> , that (I) (we) last saw the deceased alive on <u>10/21/68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (do not) view the body after death.							
22b. SIGNATURE Gregory Warpe		DEGREE ATTENDING PHYS	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 10/21/68		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/24/68	23c. NAME OF CEMETERY OR CREMATORIUM Druid Ridge Cemetery	23d. LOCATION (City or Town) Pikesville	(County) Balto. Co. Md.	(State)		
24 FUNERAL DIRECTOR Loring Byers 8728 Liberty Rd. Randallstown	ADDRESS	25a. REC'D. BY REG. STRR. OCT 24 1968	25b. REGISTRAR'S SIGNATURE Charles Judge				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16106

14113

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Gregory	Middle Palmieri	Last 	2a. DATE OF DEATH Month October	Day 20	Year 1968	2b. HOUR 1:30 P.M.
3. SEX Male	4 RACE White	5. DATE OF BIRTH 12-21-1894			6. AGE (In years last birthday) 73 YRS.	IF UNDER 1 YEAR MONTHS 	IF UNDER 24 HRS DAYS
7a. BIRTHPLACE (State or foreign country) Italy	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore				
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) retired			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland	13b. COUNTY --	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMIT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 248 S. Robinson St. #21224			
14. FATHER'S NAME Paul	First Paul	Middle Palmieri	Last 	15. MOTHER'S MAIDEN NAME 	First 	Middle 	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. 214-01-07614	17. INFORMANT Mr. Paul Palmieri	Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Pulmonary Edema						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) Acute Uremic Poisoning							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION 5/7/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (A) (this hospital) attended the deceased from Oct. 13 , 19 68 , to October 20 1968 , that (A) (we) lost saw the deceased alive on October 20 19 68 , and that in (A) (our) opinion death occurred on the date and hour and from the causes stated above, (A) (we) (did) (A) view the body after death.							
22b. SIGNATURE Jaime Punzalan		DEGREE ATTENDING PHYS.	<input type="checkbox"/>	MED. DIRECTOR	<input type="checkbox"/>	STAFF PHYS.	<input checked="" type="checkbox"/>
22d. PHYSICIAN'S NAME (Type) Jaime Punzalan, M.D.		22e. ADDRESS 7620 York Rd. #21204					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/23/68	23c. NAME OF CEMETERY OR CREMATORIAL Holy Redeemer		23d. LOCATION (City or Town) (County) (State) Baltimore Md.		
24. FUNERAL DIRECTOR Joseph J. Zanucco Jr.		ADDRESS 263 S. Broadway	25a. RECEIVED BY REGISTRAR OCT 21 1968		25b. REGISTRAR'S SIGNATURE James J. Zanucco		
30M REV 68							



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14114

1. DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b. HOUR P.M.
ABNER					PERRY	<input checked="" type="checkbox"/>	10/28	168	5:55	
3 SEX male	4. RACE white	5. DATE OF BIRTH 9-28-21	6 AGE (in years lost birthday) 47 yrs	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	HOURS MIN.				
7a BIRTHPLACE (State or foreign country) N.C.		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore		10d. HOUR P.M.	
10. CITY OR TOWN OF DEATH Baltimore (Lansdowne)			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) B & O Tracks - N. of Clyde			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Mechanic			12b KIND OF BUSINESS OR INDUSTRY Auto	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13c CITY OR TOWN Baltimore			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER 833 Woodward Street	
14. FATHER'S NAME Augustus Perry			15 IS MOTHER'S MAIDEN NAME Laura ?Gardner							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) Yes			16b SOCIAL SECURITY NO 1959-1945 565 34 6298			17 INFORMANT Mrs. Margaret Perry			ADDRESS 433 Woodward St. 21230	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Multiple Injuries</u> 8059 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 202 X										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR AM 5:55 PM 10/28 1968			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18) subj. was struck by a train				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) railroad tracks			21f. LOCATION Street or R.F.D. No City or Town County State			Baltimore, Md.	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <u>Werner U. Spitz</u> EXAMINER'S NAME (Type) Werner U. Spitz, M.D.									CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)	
23a. BURIAL CREMATION REMOVED			23b. DATE 11-1-68			23c. NAME OF CEMETERY OR CREMATORIAL Balto. National			23d. LOCATION (City or Town) (County) (State) Balto. Md.	
24. FUNERAL DIRECTOR Johnson Funeral Home			ADDRESS 8521 Loch Raven Blvd.			25a. REC'D BY REGISTRAR DATE NOV 1 1968			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

11106

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14115

1 DECEASED NAME (Type or Print)			First WILLIAM	Middle H.	Last PLOCK	2a DATE KNOWN OF ESTI. DEATH MATED	Month October	Day 5	Year 1968	2b HOUR 7 P.M.	
3 SEX Male	4 RACE White	5 DATE OF BIRTH Nov. 12, 1900.	6 AGE (In years last birthday, yrs) 67	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	IF UNDER 24 HRS HOURS 0	IF UNDER 24 HRS MIN 0	2c DATE PRONONCED DEAD Month October	Day 5	Year 1968	2d HOUR 7 P.M.
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore,						
10. CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph's Hosp.			12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) Retired Plumber			12b KIND OF BUSINESS OR INDUSTRY		
13a U.S.A. RESIDENCE (Where deceased lived, if institution admission) STATE Md.		13b COUNTY Baltimore		13c CITY OR TOWN Baltimore	13d INSIDE CITY LIMITS? YES	13e. STREET AND NUMBER 4613 Ridgeway Avenue					
14. FATHER'S NAME First Henry			Middle Plock	Last	15. MOTHER'S MAIDEN NAME First Unknown	Middle Unknown	Last				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO. (If yes give war or dates of service) 212-22-4696		17. INFORMANT Mrs. Eleanor M. Plock		ADDRESS (Same)					
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage Sudden</i> <small>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</small> (b) <i>Atherosclerotic Cardio Renal 5 yrs</i> (c) <i>Vascular Disease</i></p>											
<p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>1427</i></p>											
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES		
21a EXTERNA. CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b) Violent					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No		City or Town		County	State	
<p>22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and in my opinion death resulted from: Natural causes <input type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/></p>											
<p>ACTUAL SIGNATURE <i>Charles F. O'Donnell, M.D.</i></p>											
<p>EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.</p>											
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 10/9/68.		23c NAME OF CEMETERY OR CREMATORIUM Loudon Park Cemetery			23d LOCATION (City or Town) Baltimore, Md.		(County)	(State)	
24 FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		ADDRESS			25a. REC'D BY REGISTRAR OCT 8 1968			25b. REGISTRAR'S SIGNATURE <i>Charles J. Ruck</i>			



14107

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 10 Film G405

CERTIFICATE OF DEATH

14116

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)		First SIDNEY	Middle	Last POLLACK	2a. DATE OF DEATH Month OCTOBER	Day 2	Year 1968	2b. HOUR P.M.		
3. SEX MALE		4. RACE WHITE	5. DATE OF BIRTH AUGUST 2, 1922		6. AGE (In years last birthday) 46		IF UNDER 1 YEAR MONTHS			
7a. BIRTHPLACE (State or foreign country) HAGERSTOWN, MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE		12b. KIND OF BUSINESS OR INDUSTRY DRAPERY		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3416 MERLE DRIVE		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) SELF EMPLOYED		13a. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b. STREET AND NUMBER 3416 MERLE DRIVE		
14. FATHER'S NAME FRANK		Middle	Last POLLACK	15. MOTHER'S MAIDEN NAME First ANNA		Middle	Last	?		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes		16b. SOCIAL SECURITY NO W.W. II		17. INFORMANT MRS. ROSE POLLACK, 3416 MERLE DRIVE #21207		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last		(b) Coronary Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF last		(c) Diabetes Mellitus		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Unsure 5 yrs 10 yrs				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) None										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No	City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from Aug 7, 1968, to Oct 7, 1968, that (I) (we) last saw the deceased alive on Aug 30, 1968, and that in my (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Irving Sauber</i>		DEGREE	ATTENDING PHYS	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED Oct 7, 1968				
22d. PHYSICIAN'S NAME (Type) IRVING SAUBER		22e. ADDRESS 6905 PARK HEIGHTS AVENUE								
23a. BURIAL, CREMATON REMOVAL (Specify) BURIAL		23b. DATE 10-XX 4-68		23c. NAME OF CEMETERY OR CREMATORIUM AGUDAR BNAI JACOB LODGE		23d. LOCATION (City or Town) ROSEDALE, MARYLAND		(County)		
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		ADDRESS		25a. REC'D BY REGISTRAR DATE OCT 7 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		(State)		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used on a burial-transit permit file pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14117

1. DECEASED NAME (Type or Print)		First <i>Joseph</i>	Middle <i></i>	Last <i>Portney</i>	2a DATE KNOWN <input checked="" type="checkbox"/> Month OF EST DEATH MATED <input type="checkbox"/> 10/13 1968 5 AM	Day Year 10/13 1968 5 AM	2b HOUR 35 M				
3 SEX <input checked="" type="checkbox"/> Male	4. RACE <input checked="" type="checkbox"/> White	S DATE OF BIRTH <i>6/25/04</i>	6 AGE (in years last birthday) <i>64 YRS</i>	IF UNDER 1 YEAR MONTHS <input type="checkbox"/>	F UNDER 24 HRS DAYS <input type="checkbox"/>	HOURS <input type="checkbox"/>	M.N. <input type="checkbox"/>	2c DATE PRONONCED DEAD Month <i>10</i>	Day <i>13</i>	Year <i>1968 8 AM</i>	2d HOUR 30 M
7a. BIRTHPL.ACE (State or foreign country) <i>Russia</i>	7b CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i>							
10 CITY OR TOWN OF DEATH <i>Randallstown</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Bell Co. Gen. Hosp</i>		12a. EMPLOYMENT (Kind of work done during day even if retired) <i>Former Driver</i>		12b. KIND OF BUSINESS OR TRADE <i>Taxi Cab</i>					
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>M.D.</i>		13b. COUNTY <i>Baltimore</i>		13c CITY OR TOWN <i>Baltimore</i>		13d INSIDE CITY C.M. 157		13e STREET AND NUMBER <i>3508 Langrehr Rd</i>			
14 FATHER'S NAME First <i>Nathan</i>		Middle <i></i>	Last <i>Portney</i>	15 MOTHER'S MAIDEN NAME First <i>Mary</i>		Middle <i>Miltstein</i>	Last <i></i>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16b SOCIA. SECURID. NO. (If yes give war or dates of service, <i></i>)		17. INFORMANT <i>Mrs. Ettel Portney - 3508 H Langrehr Rd</i>		ADDRESS					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4129</i>		DUE TO, OR AS A CONSEQUENCE OF <i>Cardio-Vascular Disease</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>last</i>		(b) DUE TO, OR AS A CONSEQUENCE OF <i></i>									
(c) DUE TO, OR AS A CONSEQUENCE OF <i></i>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20 AUTOPSY?					
19c MEDICAL CERTIFICATION						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNA. CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State							
22o. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>James N. Frederick</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <i>10/13/68</i>					
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) <i>1311 Francis Ave. Baltimore Md. 21227</i>							
23a BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		23b DATE <i>10/13/68</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Cathedral Cemetery</i>		23d LOCATION (City or Town) (County) <i>Baltimore, Md.</i>		(State)			
24. FUNERAL DIRECTOR <i>John Funeral Home 6010 Patterson Park</i>		ADDRESS		25a REC'D BY REG STRR <i>OCT 17 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14118

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print)		First	Middle	Lost	2a DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b HOUR	
		EVELYN C. PRICE			<input type="checkbox"/>	10	4	1968	1:57 P.M.	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 IF UNDER 1 YEAR MONTHS DAYS	8 IF UNDER 24 HRS HOURS MIN.				2d HOUR	
Female	White	Feb. 13, 1907	61 YRS							
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Balto.				
10. CITY OR TOWN OF DEATH Towson		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		12a USUAL OCCUPATION (Kind of work done doing most of working life, even if retired.) Retired Cashier J.N.R.S.			12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13c CITY OR TOWN Balto.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 2311 Clarendon Ave.			21214		
14. FATHER'S NAME First Joseph Middle Wright Lost		15. MOTHER'S MAIDEN NAME First Christina Middle								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO. 214-01-5446		17 INFORMANT Mr. Tully A. Price			ADDRESS (Same)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic cardiovascular disease										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 443X										
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20 AUTOPSY?			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No.			City or Town	County	State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										22b. DATE SIGNED
ACTUAL SIGNATURE 										22b. DATE SIGNED October 5, 1968
EXAMINER'S NAME (Type)		Edward F. Wilson, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE 10/15/68.		23c NAME OF CEMETERY OR CREMATORIAL Parkwood Cemetery			23d LOCATION (City or Town) Baltimore, Md. (County) (State)			
24 FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		ADDRESS		25 REC'D BY REGISTRAR OCT 8 1968			25b REGISTRAR'S SIGNATURE Charles Judge			

127

Stre

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14119

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Mary	Middle Shelia	Last Puffenbarger	2a. DATE OF DEATH Month 10	Day 3	Year 68	2b. HOUR 5:35 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH 8-31-52			6. AGE (In years last birthday) 16 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. COUNTY OF DEATH Baltimore			Md
10. CITY OR TOWN OF DEATH Owings Mills	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rosewood State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Dependent			12b. KIND OF BUSINESS OR INDUSTRY none
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Wheaton	13d. INSIDE CITY LIMIT YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 11915 Center Hill Street			
14. FATHER'S NAME Norval	First Middle J.	Last Puffenbarger	15. MOTHER'S MAIDEN NAME Lucille	First Middle Hodge			Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no	16b. SOCIAL SECURITY NO. -----	17. INFORMANT Rosewood's Records	Address Owings Mills, Md. 21117				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Multiple Recurrent ulcers (Gastric)</i> 2 Mos.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
<i>341X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				<i>Progressive degenerative disease.</i>			
(b) <i>Schiedler's Disease</i>				10 yrs.			
(c) <i>Schiedler's Disease</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
<i>554</i> <i>Schiedler's Disease</i>				10 yrs.			
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from 4/4/67, to 10/3/68, that <input type="checkbox"/> (we) last saw the deceased alive on 10/3/68, and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> (we) did <input type="checkbox"/> (not) view the body after death.							
22b. SIGNATURE <i>HARRY G. BUTLER MD.</i>	22c. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 5 Oct 68					
22d. PHYSICIAN'S NAME (Type) HARRY G. BUTLER	22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/7/68	23c. NAME OF CEMETERY OR CREMATORIAL Parklawn	23d. LOCATION (City or Town) Rockville, Montg., Maryland	(County)	(State)		
24. FUNERAL DIRECTOR Tyson Wheeler funeral Home	1 ADDRESS Rockville, Md.	25a. REC'D BY REGISTRAR DATE OCT 8 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				
VR A10 30M REV 4/68							



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

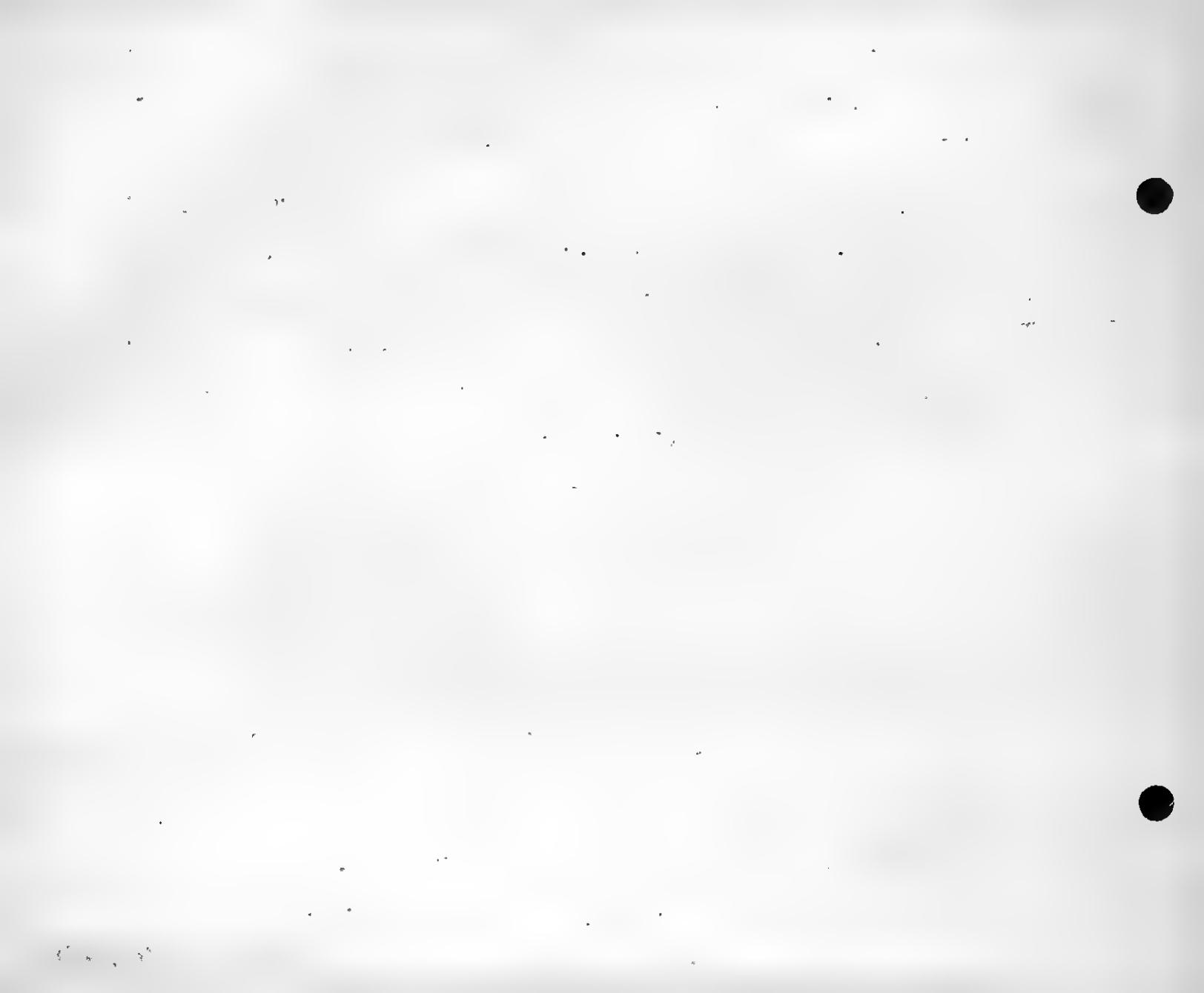
CERTIFICATE OF DEATH

14111

14120

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First FRANK	Middle NMN	Lost	2. DATE OF DEATH Month 10	Day 02	Year 68	2b. HOUR 50 5 A.M.				
3. SEX MALE		4. RACE CAU	5. DATE OF BIRTH 3-18-81			6. AGE (In years last birthday) 87 YRS		IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN	
7a. BIRTHPLACE (State or foreign country) Italy		7b. CITIZEN OF WHAT COUNTRY? Italy		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH BALTIMORE CO.							
10. CITY OR TOWN OF DEATH TOWSON, MD.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GTR. BALTO. MED. CENTER			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) Retired Chef			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Parkville		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER 8013 Ridgely Oak Rd						
14. FATHER'S NAME Dominic		Middle Quercia	15. MOTHER'S MAIDEN NAME Teresa							Middle	Lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Mrs Teresa Powell			Address Same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
DUE TO, OR AS A CONSEQUENCE OF (b) HEART INFARCTION												
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> lost. (c) INCARCERATED HERNIA												
DUE TO, OR AS A CONSEQUENCE OF												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from 9-26 , 19 68 , to 10-02 , 19 68 , that (I) (we) last saw the deceased alive on 10-02-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Dr. F. Naeim		DEGREE ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR		<input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED 10-02-68					
22d. PHYSICIAN'S NAME (Type) DR. FARAMARZ NAEIM		22e. ADDRESS G.B.M.C.										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/5/68		23c. NAME OF CEMETERY OR CREMATORIUM St John's			23d. LOCATION (City or Town) Brooklyn		(County) New York (State)			
24. FUNERAL DIRECTOR Leonard J Ruck Inc Baltimore, Maryland		ADDRESS			25a. REC'D BY REGISTRAR OCT 2 1968			25b. REGISTRAR'S SIGNATURE Charles J. Ruck				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

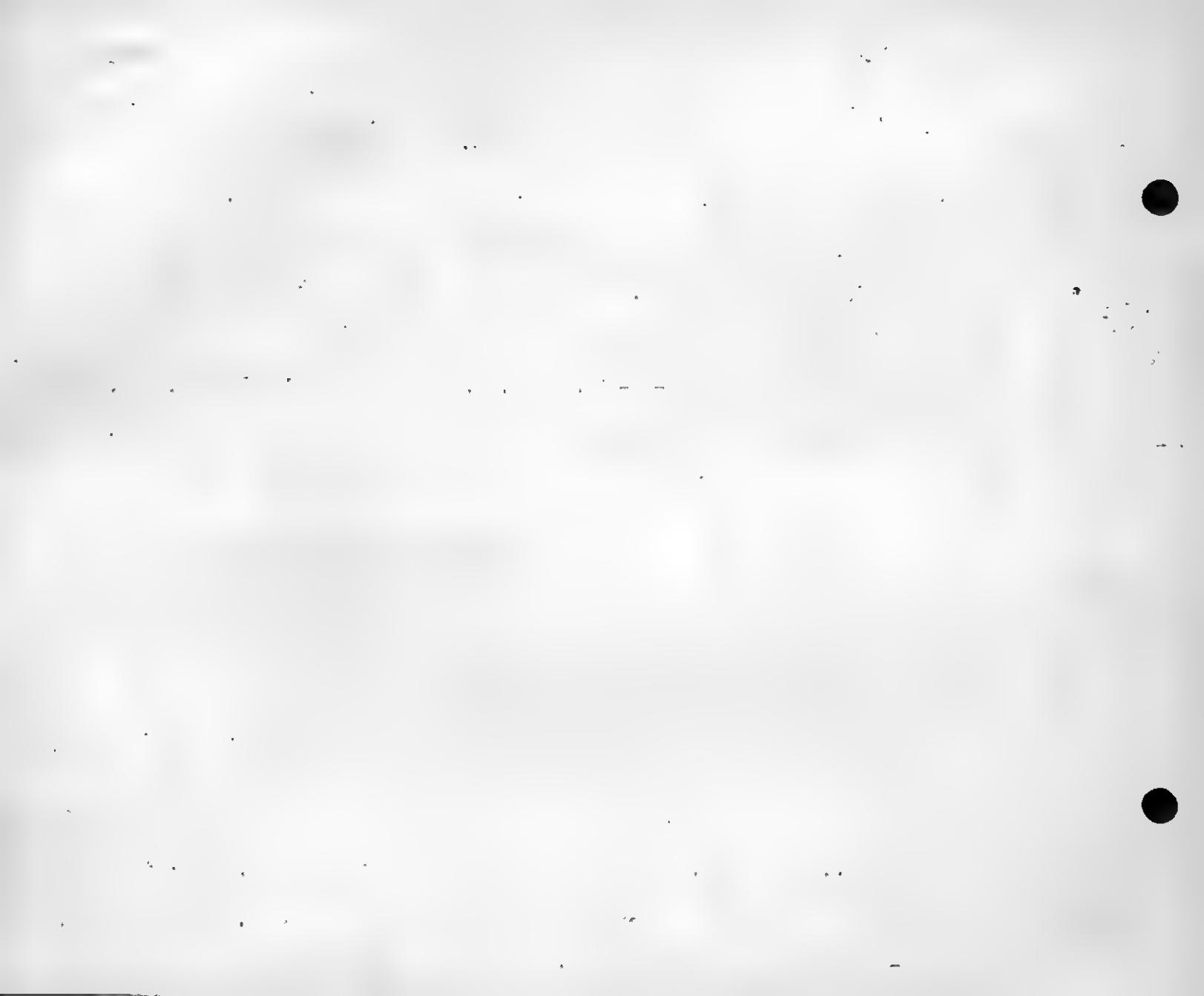
CERTIFICATE OF DEATH

14121

Within 24 hours after death.

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-tranit permit. Then please remove carbon papers pages and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First <i>Catherine</i>	Middle <i>Raley</i>	Last	2a. DATE OF DEATH Month <i>October</i>		2b. HOUR Year <i>1968</i>		
3. SEX <i>Female</i>		4. RACE <i>White</i>		S. DATE OF BIRTH Dec. 18, 1880	6. AGE (in years) Last birthday <i>87</i>		F. UNDER 1 YEAR MONTHS <i>3</i>	F. JUNIOR 24 HRS. DAYS <i>31</i>	HOURS <i>11:55 P.M.</i>
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Baltimore Co.</i>				
10. CITY OR TOWN OF DEATH <i>Upper Falls, Md.</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Bradshaw Road</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Former music teacher</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Md.</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i>		13c. CITY OR TOWN <i>Balto.</i>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER <i>Bradshaw Road</i>				
14. FATHER'S NAME First <i>Lorenz</i>		Middle <i>Krieger</i>	Last	15. MOTHER'S MAIDEN NAME First <i>Catherina</i>		Middle	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO <i>217-52-7702</i>		17. INFORMANT <i>E. B. Lassiter</i>		Address <i>642 Charles St. Ave. #21204</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: <i>Pneumonitis</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>			
4. IMMEDIATE CAUSE (a) <i>Conditions, if any, which gave rise to immediate cause (a); stating the underlying cause last.</i>		DUE TO, OR AS A CONSEQUENCE OF <i>Generalized arteriosclerosis, senility</i>							
(b) <i>DUE TO, OR AS A CONSEQUENCE OF</i>									
(c) <i></i>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
MEDICAL CERTIFICATION <i>X</i>	19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
	21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State			
22a. I certify that (I) (this hospital) attended the deceased from <i>9/10/67</i> to <i>10/31/68</i> , that (I) (we) last saw the deceased alive on <i>10/31/68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Phyllis K. Pullen M.D.</i>		22c. DEGREE <i>M.D.</i>	ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22d. DATE SIGNED <i>11/1/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>Dr. Phyllis K. Pullen</i>		22e. ADDRESS <i>Box 381 Jerusalem Rd., Kingsville, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>entombment</i>	23b. DATE <i>11/2/68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Lorraine Park Mausoleum</i>	23d. LOCATION (City or Town) <i>Balto.</i>	(County) <i>Md.</i>	(State)				
24. FUNERAL DIRECTOR <i>Mitchell-Wiedefeld Home</i>	ADDRESS <i>6500 York Rd. #21212</i>	25a. RECEIVED BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					
VR A15 30M REV 1-68		DATE <i>NOV 4 1968</i>							



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

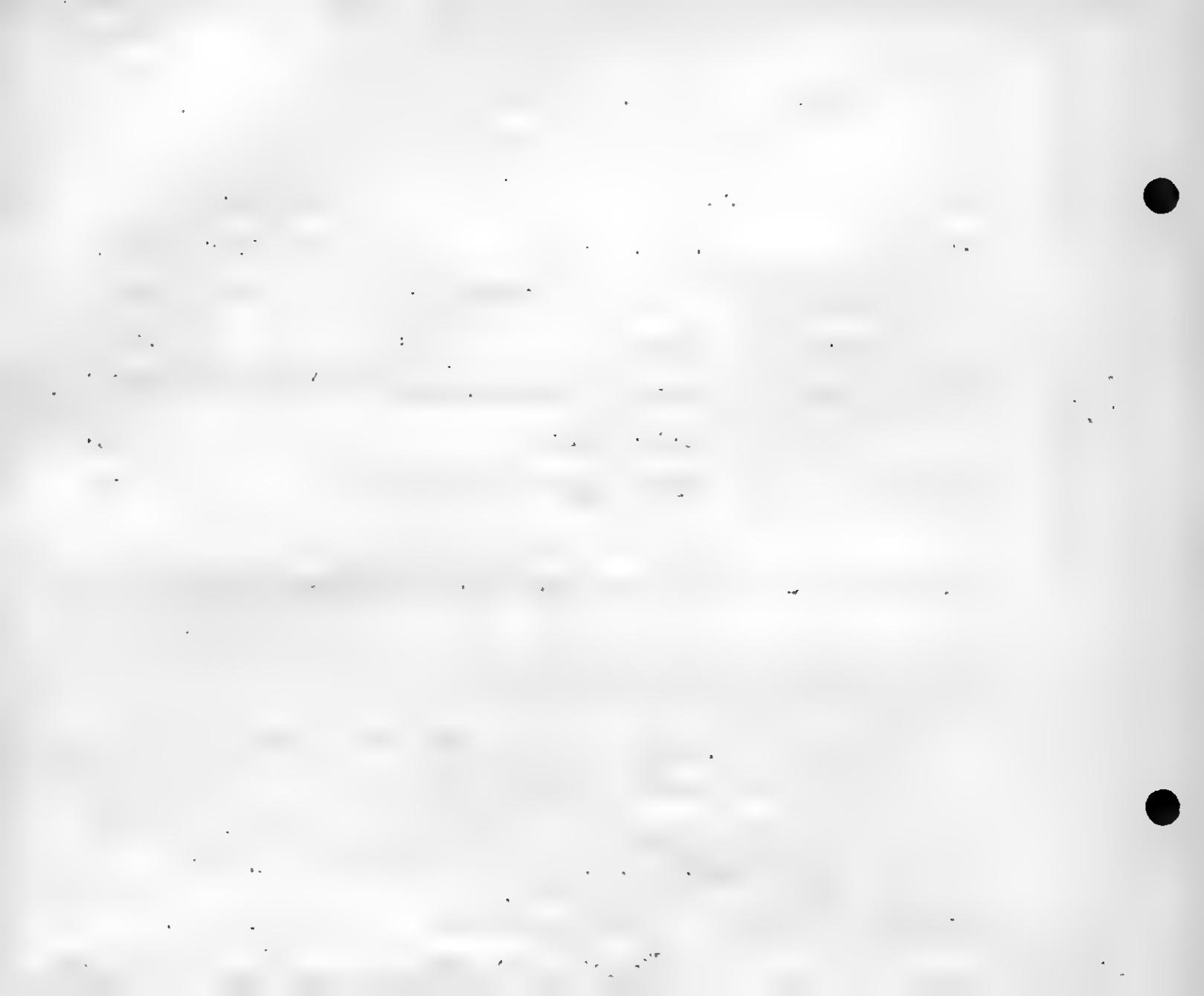
14122

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2. This certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1	14118	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										14122		
CERTIFICATE OF DEATH														
1. DECEASED NAME (Type or print)	First CHARLES			Middle J.	Lost RANKE	2d. DATE OF DEATH Month 10			2b. HOUR Day 4			Year 68	2:30 AM	
3. SEX MALE	4. RACE WHITE			5. DATE OF BIRTH 5/24/91			6. AGE (In years last birthday) 77			IF UNDER 1 YEAR MONTHS YRS			IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			9. COUNTY OF DEATH BALTIMORE COUNTY,						Md.	
10. CITY OR TOWN OF DEATH FORT HOWARD	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VET A.M. HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during time of death if deceased was working) SHEET METAL WORKER			12b. KIND OF BUSINESS OR INDUSTRY STEEL							
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND	13b. COUNTY	13c. CITY OR TOWN BALTIMORE			13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			13e. STREET AND NUMBER 3916 Dudley Avenue						
14. FATHER'S NAME First HERMAN	Middle RANKE	Lost	15. MOTHER'S MAIDEN NAME First MARY			Middle GREENWALD	Lost							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) WW I 216 05 61 31	17. INFORMANT Mary Ranke (Nee Szetebely) above, wife CLIN.RECORDS, VA HOSPITAL FT HOWARD, MD.												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL EDEMA DUE TO, OR AS A CONSEQUENCE OF (b) BRAIN TUMORS, TYPE UNDETERMINED DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC HEART DISEASE, OLD. PULMONARY EMPHYSEMA MARKED, OLD													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH RECENT	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ARTERIOSCLEROTIC HEART DISEASE, OLD. PULMONARY EMPHYSEMA MARKED, OLD													OLD	
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES						
					<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)												
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.			City or Town			County			State			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10/3/68 , 19 68 , to 10/4/68 , 19 68 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 10/4/68 , 19 68 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> view the body after death.														
22b. SIGNATURE <i>John D. Talbert, M.D.</i>	DEGREE ATTENDING PHYS	<input type="checkbox"/> MED DIRECTOR			<input type="checkbox"/> STAFF PHYS			<input checked="" type="checkbox"/>			22c. DATE SIGNED 10/4/68			
22d. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.	22e. ADDRESS VAH FORT HOWARD, MARYLAND													
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 10/7/68	23c. NAME OF CEMETERY OR CREMATORIUM CREST LAWN CEMETERY			23d. LOCATION (City or Town) BALTIMORE, MD.			(County) BALTIMORE, MD.			(State)			
24. FUNERAL DIRECTOR	ADDRESS SCHIMUNEK FUNERAL HOME OCT 7 1968			25a. REGISTRATION NUMBER DATE			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							
VR A15 30M REV. 10/68														



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 14114			14123										
1 DECEASED NAME (Type or print)			First Elizabeth	Middle Ann	Last Reed	2a. DATE OF DEATH Month October		Day 29	Year 1968	2b. HOUR 4:45 a.m.			
3. SEX female			4. RACE white	5. DATE OF BIRTH Nov. 19, 1888			6. AGE (In years last birthday) 79		YRS	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MN
7a. BIRTHPLACE (State or foreign country) Delaware		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore							
10. CITY OR TOWN OF DEATH Catonsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife - School Board			12b. KIND OF BUSINESS OR INDUSTRY Board				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Parkville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 2704 Taylor Avenue					
14. FATHER'S NAME First James Grimes			Middle Last	15. MOTHER'S MAIDEN NAME First Susan			Middle Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO 214-26-9273			17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from May 2 , 19 68 , to Oct. 29 , 19 68 , that (I) (we) last saw the deceased alive on Oct. 29 , 19 68 , and that in (I) (we) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE 		22c. DEGREE ATTENDING PHYS.			MED. DIRECTOR		STAFF PHYS.		DATE SIGNED 10-29-68				
22d. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.		22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/1/68.		23c. NAME OF CEMETERY OR CREMATORIAL Parkwood Cemetery			23d. LOCATION (City or Town) Baltimore, Md.		(County)		(State)		
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		ADDRESS			25a. REC'D BY REGISTRAR OCT 30 1968			25b. REGISTRAR'S SIGNATURE 					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14124

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First Sophia	Middle C.	Last Reider	2a. DATE OF DEATH Month 10	Day 23	Year 1968	2b. HOUR M			
3. SEX Female		4 RACE Can.		5. DATE OF BIRTH 12-9-1900		6. AGE (In years last birthday) 67 YRS.		IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS HOURS 0	MIN. 00	
7a. BIRTHPLACE (State or foreign country) Balto. Co.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore					
10. CITY OR TOWN OF DEATH Rural Pasadena		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 407 Babikow Road		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Cafeteria Worker		12b. KIND OF BUSINESS OR INDUSTRY Martins					
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 407 Babikow Road 6				
14. FATHER'S NAME First John		Middle Bartenfelder	Last 	15. MOTHER'S MAIDEN NAME First Middle Elizabeth		Last Becker					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 216-20-4642		17. INFORMANT Dorothy R. Neely		Address 8401 Hallmark Circle 34			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
<p>18. CAUSE OF DEATH (Enter only one cause per line, far (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Carcinoma of Pancreas</i></p> <p>15. / / DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF last. (c)</p> <p>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p> <p>157X</p>											
19a. DATE OF OPERATION July 1967		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of Pancreas		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> If either, notify medical examiner		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY At home, farm, street, factory OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State							
<p>22a. I certify that (I) (this hospital) attended the deceased from 7/24/1968 19 to Oct 21, 1968, that (I) (we) last saw the deceased alive on Sept 21, 1968 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</p> <p>22b. SIGNATURE <i>Robert Roubenoff</i></p>										22c. DATE SIGNED Oct 21/1968	
22d. PHYSICIAN'S NAME (Type) ROBERT ROUBENOFF		22e. ADDRESS 285 Ridge Rd 21206									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-26-1968		23c. NAME OF CEMETERY OR CREMATORIAL Moreland Cemetery		23d. LOCATION (City or Town) Baltimore		(County) City		(State) Md.	
24. FUNERAL DIRECTOR Lassahn Funeral Home		ADDRESS 7401 Belair Road 21236		25a. REC'D BY REGISTRAR OCT 28 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



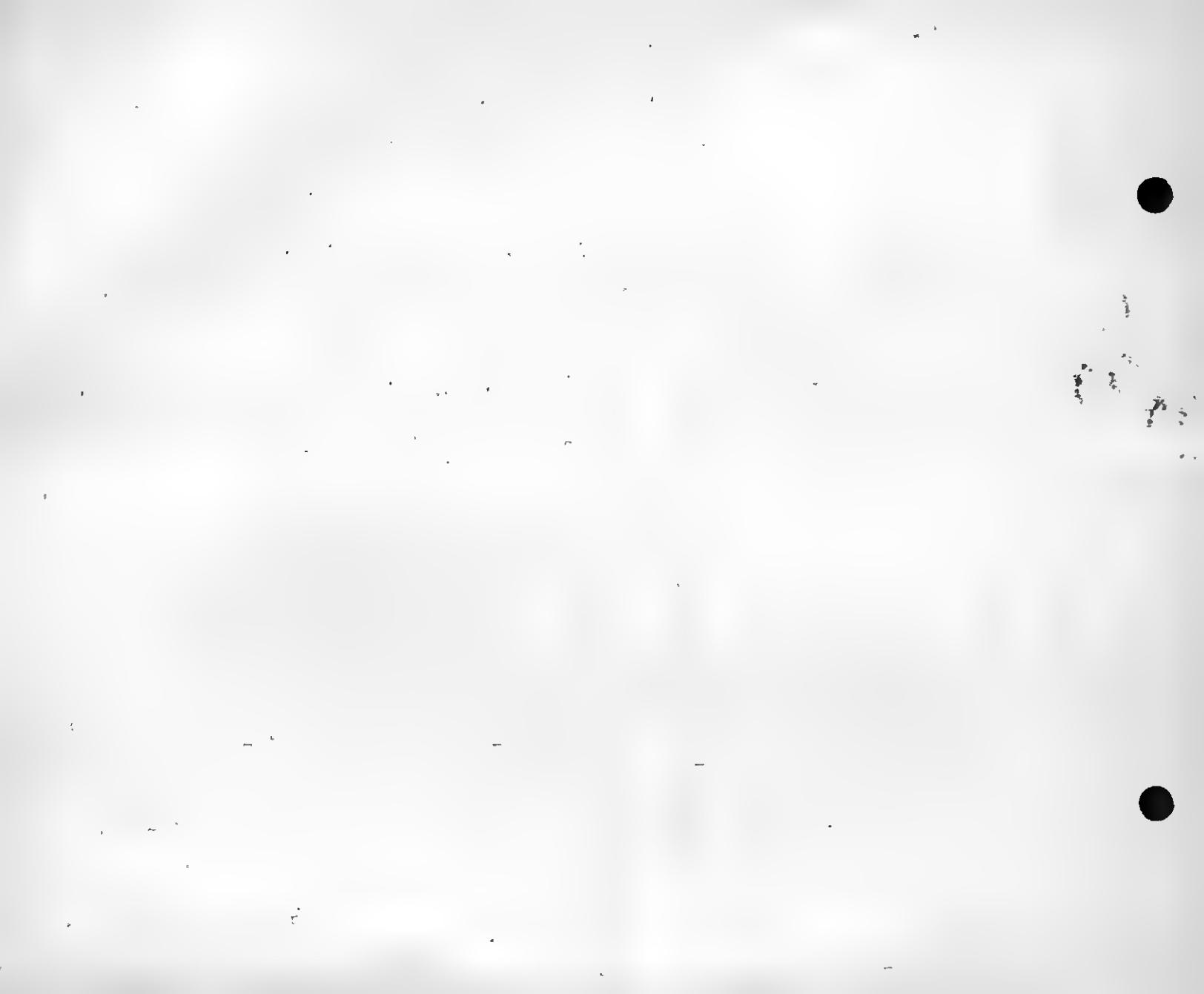
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14125

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First A.	Middle Louise	Last Reinheimer	2a. DATE OF DEATH Month Oct. 7, 1968 Day Year 1968	2b. HOUR M	
3. SEX female		4 RACE white		S. DATE OF BIRTH Feb. 5, 1882	6 AGE (In years last birthday) 86 yrs.	F UNDER 1 YEAR MONTHS DAYS HOURS M N	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore		
10. CITY OR TOWN OF DEATH Stoneleigh		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 500 Stoneleigh Rd.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. CITY OR TOWN COUNTY Baltimore		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 500 Stoneleigh Rd.	
14. FATHER'S NAME Charles		First Middle Rose	Last Lost	15. MOTHER'S MAIDEN NAME Louise	Middle	Lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO (If yes give war or dates of service) 413-20 8786		17. INFORMANT Arthur E. Reinheimer	Address 500 Stoneleigh Rd. #12		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis Generalized</u> DUE TO, OR AS A CONSEQUENCE OF (c)							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 Days							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) None							
19a. MEDICAL CERTIFICATION None		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>4-21</u> , 19 <u>66</u> , to <u>10-7</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>10-6</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Paul G. Herold, M.D.</i>		DEGREE ATTENDING PHYS.	MED DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 10-8-68		
22d. PHYSICIAN'S NAME (Type) Dr. Paul Herold		22e. ADDRESS 10 W. Madison St.					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 10/10/68		23c. NAME OF CEMETERY OR CREMATORIAL Oaklawn		23d. LOCATION (City or Town) (County) (State) Baltimore County, Md.	
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home 6500 York Rd. Balto., Md. 21212		ADDRESS		25a. REC'D. BY REGISTRAR DATE OCT 17 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

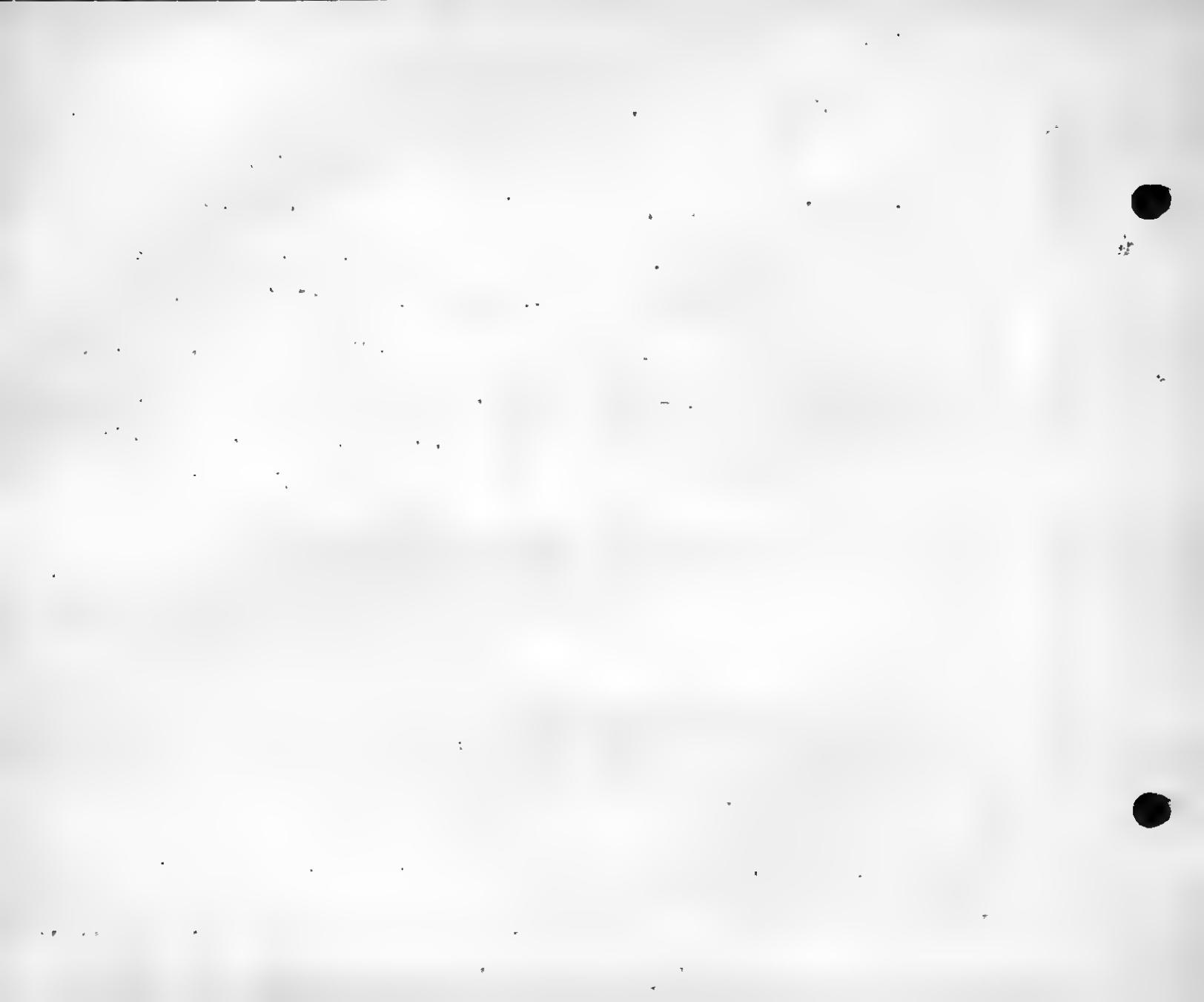
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2. This director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2. This should be filed with the State Dept. of Health prior to removal, and in any event, within 72 hours after death.

14117

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14126

1. DECEASED NAME (Type or print)	First William	Middle G.	Last Rhodes	2a. DATE OF DEATH Month 10 Day 25 Year 68	2b. HOUR 3:45 A.M.			
3. SEX Male	4 RACE White	S. DATE OF BIRTH 10/27/83	6 AGE (in years last birthday) 84 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a BIRTHPLACE (State or foreign country) West Virginia	7b CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Baltimore					
10. CITY OR TOWN OF DEATH Baltimore 21204	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Salesman	12b KIND OF BUSINESS OR INDUSTRY Shoes					
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE Maryland	13c CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 6105 York Road					
14 FATHER'S NAME First James	Middle Rhodes	15. MOTHER'S MAIDEN NAME First Sarah	Middle S.	Last Bennett				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No	16b. SOCIAL SECURITY NO. 213-07-6202A	17. INFORMANT Mrs. Mae Rhodes	Address (Same)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Acute myocardial infarct - 7/2 hr</i> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <u>lost</u> (b) DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201								
19a. DATE OF OPERATION 4/20/68	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 	20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) 					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.) 	21f. LOCATION Street or R.F.D. No. 	City or Town 	County 	State 		
22a. I certify that (I) (this hospital) attended the deceased from 10/25/68 , to 10/25/68 , 19 68 , that (I) (we) lost saw the deceased alive on 10/25/68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>John A. Mitchell</i>		DEGREE 	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 10/25/68		
22d. PHYSICIAN'S NAME (Type) JOHN A MITCHELL		22e. ADDRESS St. Joseph Hospital						
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment	23b. DATE 10/28/68	23c. NAME OF CEMETERY OR CREMATORIUM Parkwood Mausoleum	23d. LOCATION (City or Town) Parkville, Balto. Co. Md.	(County) 	(State) 			
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.	ADDRESS 4905 York Rd. Balto. 12, Md.	25a. REC'D BY REGISTRAR OCT 25 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					
VR A15 30M REV 12/68								





FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary; please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14128

1. DECEASED NAME (Type or Print)			First HARVEY	Middle M. ARC	Last RICHMAN	2a DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/>	Month Oct.	Day 8,	Year 1968	2b HOUR A: 00	
3 SEX male	4 RACE white	5. DATE OF BIRTH 7-11-1968	6 AGE (In years last birthday) - yrs 3	IF UNDER 1 YEAR MONTHS 3	IF UNDER 24 HRS DAYS 0	MIN. 0	2c DATE PRONOUNCED DEAD Month October	Day 8,	Year 1968	2d HOUR A: 00	
7a BIRTHPLACE (State or foreign country) Baltimore, Md.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Baltimore					
10. CITY OR TOWN OF DEATH REISTERSTOWN			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) BALTO. Co. Gen. Hosp.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) NONE			12b KIND OF BUSINESS OR IND.STRY NONE		
13a US/JAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e STREET AND NUMBER 4707 Maryknoll Road					
14 FATHER'S NAME First MYRON			Middle RI	Last CHMAN	15 MOTHER'S MAIDEN NAME First CHARLENE			Middle KIRSON	Last KIRSON		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b SOCIAL SECURITY NO. (If yes give war or dates of service) NO			17 INFORMANT MR. JEROME KIRSON, 8533 STEVENSWOOD RD. #7			ADDRESS		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Interstitial Pneumonitis (SDII) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> last. 707 X (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 515X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No. City or Town County State							
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Werner U. Spitz, M.D.</i>		EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED 10/8/68			
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE 10-9-68		23c NAME OF CEMETERY OR CREMATORIAL HEBREW YOUNG MEN			23d LOCATION (City or Town) BALTIMORE, MARYLAND			(County) MARYLAND	(State)
24 FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		ADDRESS			25a REC'D BY REGISTRAR OCT 9 1968			25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15120

CERTIFICATE OF DEATH

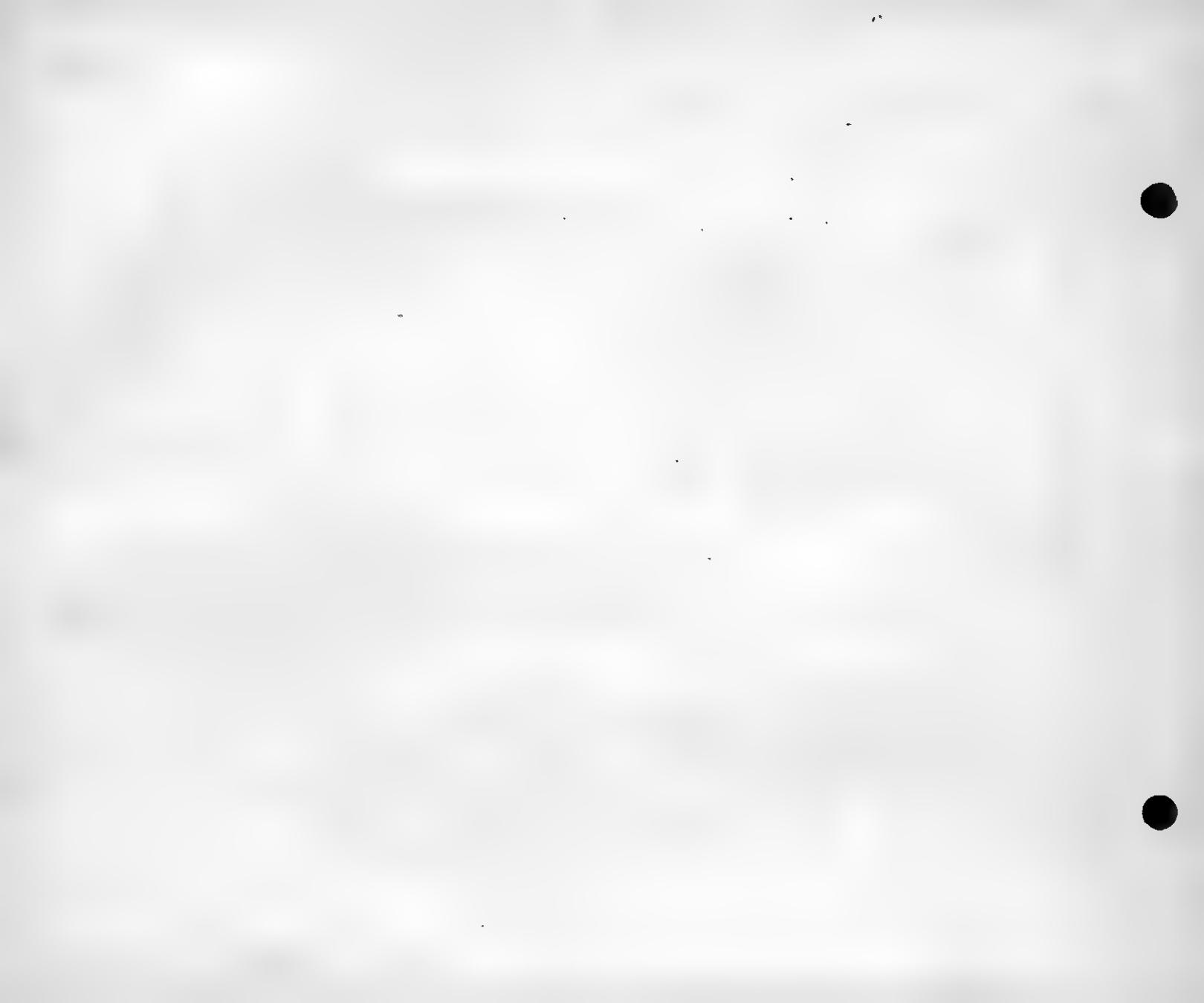
14129

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-tranit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rurah LUTHERVILLE</u>		c. LENGTH OF STAY IN b <u>yes.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Same as 2.d. Lutherville</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville, Md.</u>	
3. NAME OF DECEASED (Type or print) <u>EMMA ELIZABETH</u>		First <u>E</u> Middle <u>M</u> Last <u>I</u>	4. DATE OF DEATH <u>10/27/1968</u>
S. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/24/1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	9. AGE (In years last birthday) <u>91 yrs</u>
13. FATHER'S NAME <u>Duke</u>		11. BIRTHPLACE (County & State or foreign country) <u>Baltimore, Md.</u>	
14. MOTHER'S MAIDEN NAME <u>Cecilis O'Brien</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No None</u>		16. SOCIAL SECURITY NO <u>216-14-0390</u>	17. INFORMANT <u>Mrs. Margaret A. Volland</u> Address <u>Lutherville Md., Box 459</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Viremia</u> DUE TO <u>viral bronchitis</u> (c) _____		19. INTERVAL BETWEEN ONSET AND DEATH <u>several hours</u>	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <u>Myxedema</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) _____	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>10</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or Town) <u>Baltimore</u> (County) <u>Md.</u> (State) <u></u>
21. I certify that (I) (this hospital) attended the deceased from <u>10/18/1968</u> to <u>10/27/1968</u> , that (I) (we) last saw the deceased alive on <u>10/26/1968</u> , and that death occurred at <u>5:30 AM</u> , from causes and on the date stated above.		22b. DATE SIGNED <u>10/27/1968</u>	
22a. SIGNATURE <u>Gerald N. Maggid, M.D.</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. ADDRESS <u>Pikesville Medical Center - Baltimore, Md. 21209</u>
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial Oct. 30, 1968 New Cathedral Cemetery</u>		23b. DATE THEREOF <u>Oct. 30, 1968</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>New Cathedral Cemetery</u>
24. FUNERAL DIRECTOR <u>Frank J. Neely, Pikesville, Md.</u>		ADDRESS <u></u>	25a. REC'D BY REGISTRAR <u>NOV 4 1968</u>
			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**
CERTIFICATE OF DEATH

19 16121

14130

1. DECEASED NAME (Type or print) Cyril			First	Middle	Lost	2a. DATE OF DEATH Month October	Day 6 , 1968	Year Year	2b. HOUR 9:15 p.m.	
3 SEX male	4 RACE Negro	5 DATE OF BIRTH February, 1902	6 AGE (In years last birthday) 66	7f. IF UNDER 24 YEARS MONTHS YRS.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore County	10. CITY OR TOWN OF DEATH Catonsville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Spring Grove State Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) retired Merchant Marine	12b. KIND OF BUSINESS OR INDUSTRY
7a. BIRTHPLACE (State or foreign country) Florida	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	13a. LSUAL RESIDENCE (Where deceased lived, if institut on admission) STATE Maryland	13b. COUNTY Baltimore City	13c. CITY OR TOWN Baltimore City	13d. INSIDE CITY LIMITS? YES	13e. STREET AND NUMBER 1916 West Mulberry Street				
14. FATHER'S NAME (dec'd.) Emanuel	First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 220-03-9351-A	17. INFORMANT Records: Spring Grove State Hospital	Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Geonadopneumonia.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			DUE TO, OR AS A CONSEQUENCE OF Recent CVA. (cerebrovasc. accident)							
			DUE TO, OR AS A CONSEQUENCE OF Diabetes Mellitus.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 260 x										
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State					
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from Aug. 7, 1968 , to Oct. 6, 1968 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Oct. 6, 1968 , and that in (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (we) <input type="checkbox"/> (did not) view the body after death										
22b. SIGNATURE Rafael H. Marin, M.D.	DEGREE	ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 10-7-68					
22d. PHYSICIAN'S NAME (Type) Rafael H. Marin, M.D.	22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228									
23a. BURIAL, CREMATON, REMOVAL (Specify) Burial	23b. DATE 10/10/68	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Calvary	23d. LOCATION (City or Town) Brooklyn, Maryland	(County)	(State)					
24. FUNERAL DIRECTOR Charles A. Rice	ADDRESS 661 W. Barre St.	25a. REC'D BY REGISTRAR OCT 8 1968	25b. REGISTRAR'S SIGNATURE Charles Judge							

be executed within 24 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15122

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 CERTIFICATE OF DEATH

14131

1. DECEASED NAME (Type or print)	First <u>Lester</u>	Middle <u>L.</u>	Last <u>Robinson</u>	2a. DATE OF DEATH Month <u>10</u> Day <u>27</u> Year <u>1968</u>	2b. HOUR <u>27</u> M
3. SEX <u>Male</u>	4 RACE <u>W</u>	5. DATE OF BIRTH <u>6-18-79</u>		6. AGE (In years last birthday) <u>81</u> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>	7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <u>Baltimore</u>		Md.
10. CITY OR TOWN OF DEATH <u>Columbia</u>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Summit</u>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Businessman</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Businessman</u>	
13a. USUAL RESIDENCE (Where deceased admission) STATE <u>Md</u>	13b. COUNTY <u>Howard</u>	13c. CITY OR TOWN <u>Northwood Park</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <u>1115 Loudon Ave.</u>	
14. FATHER'S NAME <u>George</u>	First <u>Lester</u>	Middle <u>L.</u>	Last <u>Robinson</u>	15. MOTHER'S MAIDEN NAME First <u>Mary C.</u>	Middle <u>Clara</u>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>No</u>	16b. SOCIAL SECURITY NO. <u>705-05-4051</u>	17. INFORMANT <u>Mr. Lester L. Robinson, Jr.</u>	Address <u>4524 Northwood Dr</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ADENOCARCINOMA OF THE RECTUM</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Distant metastatic carcinomatous disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>1541</u>					
19a. DATE OF OPERATION <u>1/4/68</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <u>19</u>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY (OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>SEPT 28, 1968</u> to <u>OCT 2, 1968</u> , that (I) (we) last saw the deceased alive on <u>SEPT 30, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>S. Kasai, M.D.</u>		DEGREE <u>M.D.</u>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22d. PHYSICIAN'S NAME (Type) <u>E. KASAI, M.D.</u>		22e. ADDRESS <u>1801 FREDERICK RD., BALTIMORE 21228</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>10-5-1968</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Loudon Park Cemetery</u>		23d. LOCATION (City or Town) <u>Baltimore, Maryland</u> (County) (State)
24. FUNERAL DIRECTOR <u>Howard H. Hubbard</u>		ADDRESS <u>4107 Wilkens Ave. 21229</u>	25a. REC'D BY REGISTRAR DATE <u>OCT 4 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
VR A 51-1 30M REV 1-68					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14132

15123

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Page 4 may be retained by the hospital or attending physician. This certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR 10-11
		Irene		Roe	10-	11	68	10.30
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 24 HRS.
Female		White		1-1-1892		76 yrs.		MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Talbot Co., Md.		USA				Baltimore		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		
Woodlawn		6408 Walnut Street				School Teacher		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		Residence before		13c. CITY OR TOWN		13d. INSIDE CITY LIMIT?	13e. STREET AND NUMBER	
MD		Balto		Woodlawn		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	X 6408 Walnut Street 21207	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last
		William	E.	Roe	Ida		William	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
NO		215-40-4723A		Edith W. Mills - 6408 Walnut Street 21207				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arterio-Sclerotic Heart Disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <u>Pyelonephritis</u> (b) <u>2 yrs.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Arterio Scler</u> DUE TO, OR AS A CONSEQUENCE OF								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>420c</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) 19				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept. 19 1968</u> , to <u>Oct. 11 1968</u> , that (I) (we) last saw the deceased alive on <u>Oct. 10 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) (did not) view the body after death.								
22b. SIGNATURE <u>Earl L. Chambers</u>		DEGREE ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <u>10/12/68</u>		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <u>Earl L. Chambers - Dr. W. bold Spring Lane - Balto</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10-14-68</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Springhill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Easton, Maryland</u>			
24. FUNERAL DIRECTOR <u>Ellsworth Armacost - 4600 Liberty Hghts. Avenue</u>		ADDRESS <u>30M REV. 30M REV.</u>		25a. OCT BY REGISTRATION DATE <u>OCT 4 1968</u>		25b. FUNERAL'S SIGNATURE <u>Peter J. Judge</u>		



FOR STATE
HEALTH DEPT.

Any delay is
necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner. File pages 1, 2, and 3 along with form PAN 3
5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 along with the State Department of
Health prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14133

1 DECEASED NAME (Type or Print)	First	Middle	Last	2a DATE KNOWN OF EST DEATH MATED	Month	Day	Year	2b HOUR M	
Vernon T. Ruggles Jr.				October 13 1968 4P.M.					
3 SEX male	4 RACE white	5 DATE OF BIRTH 9/15/22	6 AGE (in years last birthday) 46 yrs	7 IF UNDER 1 YEAR MONTHS	8 IF UNDER 24 HRS. DAYS	9 IF UNDER 24 MRS. HOURS	10 IF UNDER 24 MIN.	2c DATE PRONOUNCED DEAD Month October 13	2d HOUR Year 1968 4P.M.
7a BIRTHPLACE (State or foreign country) Baltimore	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9 COUNTY OF DEATH Baltimore						
10. CITY OR TOWN OF DEATH Baltimore	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) St. Joseph Hospital	12b KIND OF BUSINESS OR INDUSTRY						
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md	13b COUNTY Baltimore	13c CITY OR TOWN Baltimore	13d INSIDE CITY, M.T.S.P. YES	13e STREET AND NUMBER 4301 Kolb Ave. 21206					
14 FATHER'S NAME Vernon T. Ruggles Sr.	15 MOTHER'S MAIDEN NAME Elsie Ditzel								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No Yes	16b SOCIAL SECURITY NO. 214-14-0691	17 INFORMANT Mrs. Elsie Hornig	ADDRESS 306 S. Maderia Street						
8 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) 19							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No.	City or Town	County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Charles F. O'Donnell</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.			22b DATE SIGNED 10/13/68					
EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			ADDRESS (Street, city, town, or county)					
23a BURIAL, CREMATON, REMOVAL (Specify) Burial	23b DATE 10-17-1968	23c NAME OF CEMETERY OR CREMATORIUM Moreland Memorial Park	23d LOCATION (City or Town) Baltimore County, Maryland	(County) (State)					
24 FUNERAL DIRECTOR Lilly & Zeiler Inc.	ADDRESS 1901-07 Eastern Ave.	25a REC'D BY REGISTRAR DATE OCT 14 1968	25b REGISTRAR'S SIGNATURE Charles Judge						

1975

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15125

14134

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)			First Lillian	Middle Pauline	Last Sachs	20. DATE OF DEATH Month 10	Day 12	Year 68	2b. HOUR 5:45a			
3. SEX Female		4. RACE Caucasian	5. DATE OF BIRTH 4-19-02			6. AGE (In years last birthday) 66		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore						
10. CITY OR TOWN OF DEATH Towson, Maryland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater. Balt. Med. Cent.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY at home				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Balto.	13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES		13e. STREET AND NUMBER 4624 Crosswood Ave.		21214			
14. FATHER'S NAME Joseph		First Vana	15. MOTHER'S MAIDEN NAME unknown							Middle		Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 216-12-0926 B		17. INFORMANT John F. Sachs, husband, above			Address				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure												
DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of lung												
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause <u>lost</u>												
DUE TO, OR AS A CONSEQUENCE OF (c) Obstruction of main stem bronchus												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 10 Month 07 Day 19 Year 68 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) Hooshang Meshkinpour attended the deceased from 10-07 , 19 68 , to 10-12 , 19 68 , that (I) last saw the deceased alive on 10-12 , 19 68 and that in (my) opin ion death occurred on the date and hour and from the causes stated above, (I) last (did) view the body after death.												
22b. SIGNATURE Meshkinpour		DEGREE Hooshang		ATTENDING PHYS. Meshkinpour		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 10-12-68		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 6701 Charles St.										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/15/68		23c. NAME OF CEMETERY OR CREMATORIAL Balto. Nat. Cem.			23d. LOCATION (City or Town) Balto. Md.		(County)		(State)	
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. ADDRESS 3331 Brehms Lane						25a. REC'D BY REGISTRAR DATE OCT 15 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				



1 14126 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH 14135

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages A and B should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First <i>Odilia</i>	Middle <i>Sandner</i>	Lost	20. DATE OF DEATH Month <i>October</i> Day <i>28</i> Year <i>1968</i> 6:10 PM	26 HOUR
3. SEX <i>F</i>	4. RACE <i>White</i>	S. DATE OF BIRTH Oct. 15, 1878	6. AGE (In years last birthday) <i>90 yrs.</i>	F UNDER 1 YEAR MONTHS <i>9</i>	IF UNDER 24 HRS DAYS <i>0</i>
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Baltimore</i>	12b. KIND OF BUSINESS OR OCCUPATION <i>Womans Exchange</i>	
10. CITY OR TOWN OF DEATH <i>Randallstown</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Beth N. Home</i>	12a. USUAL OCCUPATION (Kind of work done during working hours, even if retired) <i>Needle Work</i>	12b. KIND OF BUSINESS OR OCCUPATION <i>Womans Exchange</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>Balto.</i>	13c. CITY OR TOWN <i>Balto.</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>1010 Walnut Ave. 21229</i>	
14. FATHER'S NAME <i>John Sandner</i>	First	Middle	Lost	15. MOTHER'S MAIDEN NAME <i>Anna Lucke</i>	Middle
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO. <i>213-54-0048</i>	17. INFORMANT <i>H. Lucke (Cousin)</i>	Address <i>Randallstown 927-5725</i>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i>	
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Arteriosclerosis - generalized</i>					
DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) _____					
19a. MEDICAL CERTIFICATION DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILD NG, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>July 26, 1967</i> , to <i>October 28, 1968</i> , that (I) (we) last saw the deceased alive on <i>October 28, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>C. E. McWilliams</i>	DEGREE ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>Oct 28, 1968</i>	
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS <i>11904 Reisterstown Rd. Reisterstown Md</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>Oct. 31, 68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Loudon Park Cemetery</i>	23d. LOCATION (City or Town) <i>Baltimore Maryland</i>	(County) <i>(County)</i>	(State) <i>(State)</i>
24. FUNERAL DIRECTOR <i>Loring Byers</i>	ADDRESS <i>8728 Liberty Rd. Randallstown, md</i>	25a. REC'D BY REGISTRAR DATE <i>OCT 31 1968</i>	25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14136

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Theresa M. Schanken			October 28 1968		M
3. SEX F	4. RACE W	5. DATE OF BIRTH 4-25-1893		6. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore	12b. KIND OF BUSINESS OR INDUSTRY
10. CITY OR TOWN OF DEATH Violetsville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3808 Coolidge Avenue			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife & Ret. Cook	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Violetsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 3808 Coolidge Avenue 21229	
14. FATHER'S NAME First Joseph	Middle H	Last Carter	15. MOTHER'S MAIDEN NAME First Mary Heidrich	Middle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO 216-03-9345A	17. INFORMANT Marie Haynie	Address 21229 3808 Coolidge Ave., Violetsville		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Pancreas</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 mos					
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Diabetes Mellitus</i>					
19a. DATE OF OPERATION July 8 1968	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Abdominal tumor</i>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At Home Farm, Street, Factory) <i>Office building etc.</i>	21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 5</i> , 1968, to <i>Oct 18</i> , 1968, that (I) (we) last saw the deceased alive on <i>Oct 5</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Earl Passmo</i>	DEGREE ATTENDING PHYS	22c. DATE SIGNED 10-29-68			
22d. PHYSICIAN'S NAME (Type) Dr. Earl I. Pass	22e. ADDRESS 4001 Wilkens Avenue, Baltimore Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11-1-68	23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cemetery	23d. LOCATION (City or Town) Baltimore City, Baltimore Md.	(County) Baltimore City, Baltimore Md.	(State)
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. Balto	ADDRESS 21229	25a. RECD BY REG. STRAR DATE OCT 31 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

14137

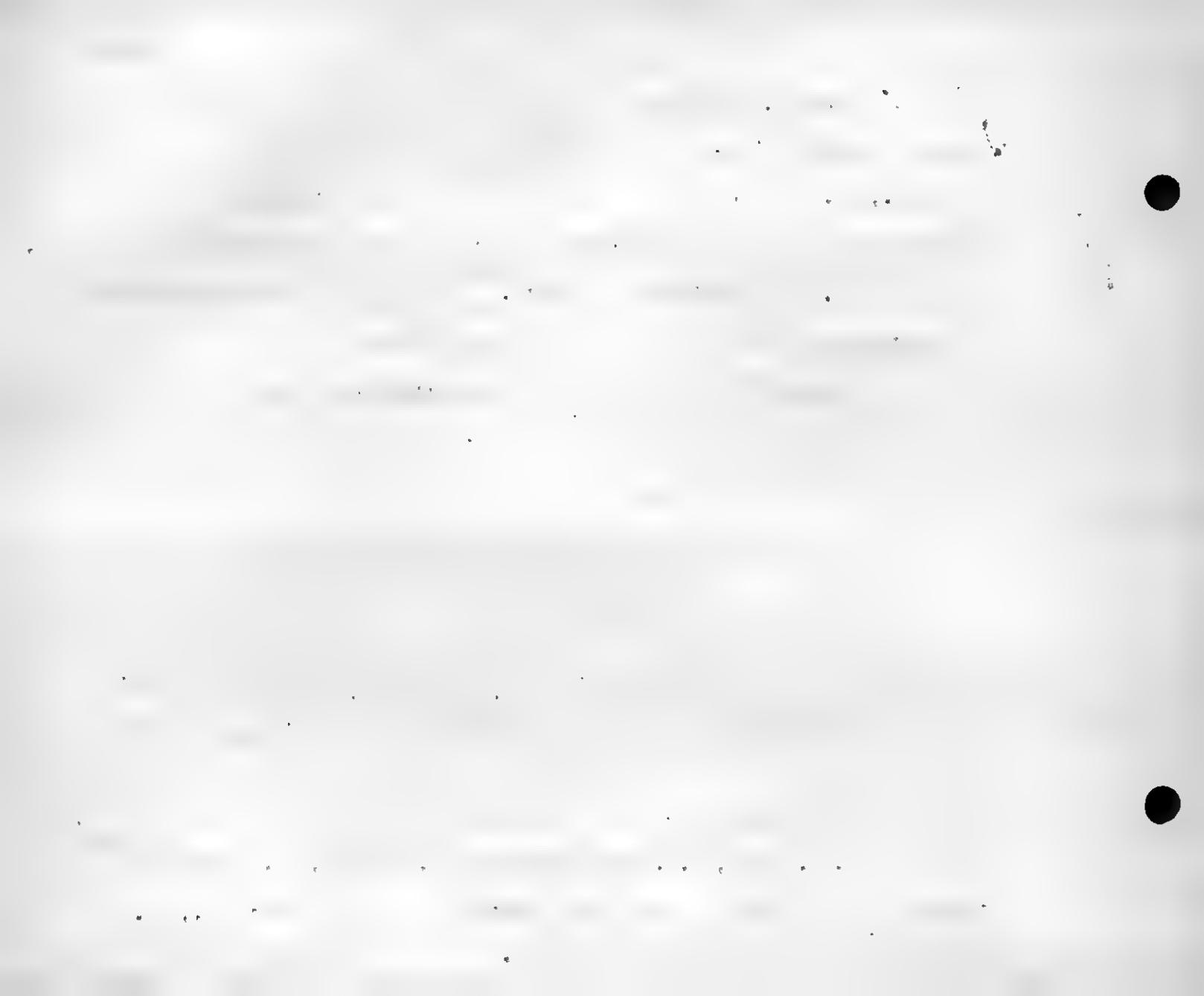
~~FOR STATE
HEALTH DEPT.~~

18. Give Pages 1, 2, and 3 to
the long with form PM2 PGS
with the State Depar

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3-1075. S may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED-NAME CARL H. SCHNEIDER				First	Middle	Last	2a DATE KNOWN OF ESTI DEATH MATED	Month	Day	Year	2b. MO.JR 87	
3 SEX Male	4. RACE White	5 DATE OF BIRTH 3/4/29	6 AGE (in years last birthday) 39	7f. IF UNDER 1 YEAR YRS	7f. IF UNDER 24 HRS MONTHS	7f. IF UNDER 24 HRS DAYS	7f. IF UNDER 24 HRS HOURS	7f. IF UNDER 24 HRS MINS	2c. DATE PRONOUNCED DEAD 10/16	2d. DAY Mon	2d. MONTH Oct	2d. YEAR 1968
7a BIRTHPLACE (State or foreign country) Balto., Md.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore				
10 CITY OR TOWN OF DEATH Essex (21221)		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Bay Avenue (Rural)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Computer Technician				12b. KIND OF BUSINESS OR INDUSTRY Steel Co.				
13a USUAL RESIDENCE (Where deceased I lived, if institution admission) STATE Md.		13b. COUNTY Baltimore		13c CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER 7853 Eastdale Road						
14. FATHER'S NAME Charles Schneider		First	Middle	Last	15. MOTHER'S MAIDEN NAME Mary Duerr		First	Middle	Last			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> Yes (Yes, no, or unknown)		16b SOCIAL SECURITY NO Korean		17 INFORMANT Janice Schneider	ADDRESS Sane							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 955X		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 955X		<i>Gun Shot Wound Thru Head</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH —				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause 955X		DUE TO, OR AS A CONSEQUENCE OF (b) —										
		DUE TO, OR AS A CONSEQUENCE OF (c) —										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 976X												
19a. DATE OF OPERATION 976X		19b. CONDITION FOR WHICH OPERAT.ON WAS PERFORMED?						20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 955X		21b. TIME OF INJURY Month, Day, Year 8 AM 10/6 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Shot self in the head								
21d. N.J.RY OCCURRED AT HOME <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> Bay Ave (Home)		21e. PLACE OF INJURY (At home, farm, street, grocery store, office, business, etc.) Bay Ave (Home)		21f. LOCATION Street or R.F.D. No Bay Ave - Balt. Essex 21-Balto Md				City or Town County State				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> Undetermined manner <input type="checkbox"/> death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/>												
ACTUAL SIGNATURE M. B. Davis		EXAMINER'S NAME (Type) M. B. Davis, M.D.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 10/18/68		
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE 10/19/68		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City or Town) Baltimore Co., Md.		(County) Dundalk, Md.		(State)		
24. FUNERAL DIRECTOR Bruzdzinski Funeral Home		ADDRESS 1407 Eastern Ave.		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge		DATE OCT 21 1968				



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14128 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14138

1 DECEASED NAME (Type or Print)		First WILLIAM	Middle SCHOEBERLEIN	Lost	2a DATE KNOWN OF EST. DEATH MATED	Month Day Year October 7 1968	2b HOURS 3:00 P.M.	
3. SEX Male	4 RACE White	5 DATE OF BIRTH June 10, 1894.	6 AGE (In years at birthday) 74 YRS	7 IF UNDER 1 YEAR MONTHS DAYS HOURS M.N.	8 MARRIED NEVER MARRIED W DOWED DIVORCED	9 COUNTY OF DEATH Baltimore, Md.	2c DATE PRONOUNCED DEAD Month Day Year October 7 1968	2d HOUR 3:00 P.M.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph's Hosp.		12a. LSLA. OCCUPATION (Kind of work done during most of working life even if retired) Retired--Balto. City Police		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 3107 Moreland Avenue		
14 FATHER'S NAME First Conrad		Middle	Lost Schooberlein	15 MOTHER'S MAIDEN NAME Elizabeth		First	Middle	Last ?
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown		16b. SOCIAL SECURITY NO 220-44-6975		17 INFORMANT Mrs. Anna K. Schooberlein		ADDRESS (Same)		
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		18b. TERMINAL DISEASE Tuberculosis		18c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden				
(b) Due to, or as a consequence of Fractured Left Hip		(c) Due to, or as a consequence of Advanced Arteriosclerotic C-R Disease		18d. DURATION 7 Days		18e. DEATH CERTIFICATION 1 day		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PR. MARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21b. TIME OF INJURY Month Day Year HOUR AM/PM 9/30 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 21a) Fell down Several Steps				
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory office building, etc.) Home		21f. LOCAT ON Street or R.F.D. No. City or Town 3107 Moreland Ave Baltimore, Md.				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Charles F. O'Donnell, M.D.		CHIEF MEDICAL EXAMINER M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 10/7/68		
EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/10/68.		23c. NAME OF CEMETERY OR CREMATORIUM Parkwood Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		ADDRESS		25a. REC'D BY REGISTRAR DATE OCT 8 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



11130

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14139

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First Alfred	Middle W.	Last SCHROBSDORFF	2a. DATE OF DEATH Month 10	Day 30	Year 1968	2b. HOUR 4 A. M.		
3. SEX Male		4. RACE White		5. DATE OF BIRTH 11-19-1901		6. AGE (In years last birthday) 66 YRS.		IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN.
7a. BIRTHPLACE (State or foreign country) Germany		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore,				
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Tool Maker--Western Electric		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 7913 Oakdale Ave.				
14. FATHER'S NAME First August		Middle Schrobsdorff	Last	15. MOTHER'S MAIDEN NAME First Auguste		Middle Gunther	Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO 218-03-0832A		17. INFORMANT Mrs. Ella Schrobsdorff		Address (Same)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) Pulmonary edema PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Pulmonary embolism DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of head of pancreas with extensive metastasis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1510										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State	
22a. I certify that A (this hospital) attended the deceased from 10/15/68 , to 10/30/68 , that A (we) last saw the deceased alive on 10/30/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Christina Feliciano, M.D.</i>		DEGREE M.D.	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED 10/30/68				
22d. PHYSICIAN'S NAME (Type) Christina Feliciano, M.D.		22e. ADDRESS 7620 York Rd., Towson, Md. 21204								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/2/68.		23c. NAME OF CEMETERY OR CREMATORIAL Moreland Memorial Cem.		23d. LOCATION (City or Town) Baltimore, Md.		(County)	(State)	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		ADDRESS		25a. REC'D. BY REGISTRAR OCT 31 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				
VR A15 30M REV <i>166</i>		DATE								



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14140

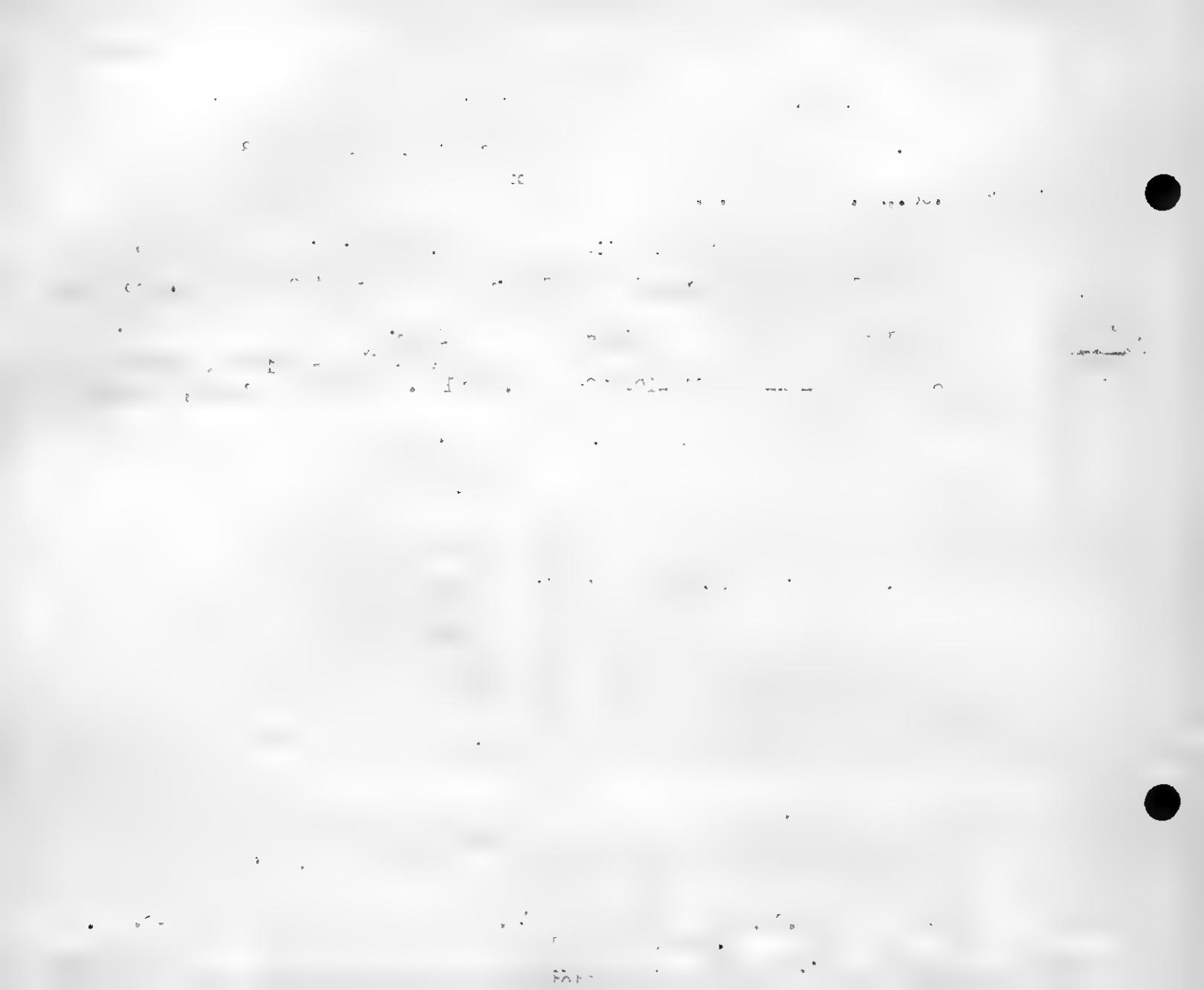
16131

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Helen	Middle Lee	Last Schurman	2a DATE OF DEATH Month 10	Day 24	Year 68	2b. HOUR 12:05
3 SEX Female	4. RACE Cau.	5. DATE OF BIRTH October 21, 1915			6. AGE (In years last birthday) 53 yrs.	F JNRD 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN
7a BIRTHPLACE (State or foreign country) Balto. Co., Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Baltimore				
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Med. Center			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Homemaker	
13a USUAL RESIDENCE (Where deceased lived, if institution Reside before admission) STATE Maryland	13b. COUNTY Harford	13c CITY OR TOWN Bel Air	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER 102 South Lynbrook Road			
14 FATHER'S NAME Alvin	First Middle Sipes	Last	15 MOTHER'S MAIDEN NAME Blanche	Middle Last Lee			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No	16b. SOCIAL SECURITY NO. 212-10-9439	17 INFORMANT (Husband) 838-5514 Mr. Paul F. Schurman			Address 102 S. Lynbrook Road Bel Air, Maryland 21014		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Widespread carcinomatosis 10/10 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) Carcinoma of right kidney DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Gastrointestinal hemorrhage from duodenal ulceration							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from 8/27, 1968, to 10/24, 1968, that (I) (we) last saw the deceased alive on 10/24, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Rudiger Breitenecker</i>	DEGREE ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED 10/24/68			
22d. PHYSICIAN'S NAME (Type) Rudiger Breitenecker, M.D.	22e. ADDRESS 6701 N. Charles Street						
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Oct. 26, 1968	23c NAME OF CEMETERY OR CREMATORIAL Fairview Meth. Ch. Cem.	23d LOCATION (City or Town) Sunnybrook		(County) Balto. Co., Md.	(State)	
24. FUNERAL DIRECTOR <i>Foster Funeral Home Bellair Md.</i>	W. Broadway ADDRESS Williams	25a REG. # 10748	25b. DATE 10-24-68	25c. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

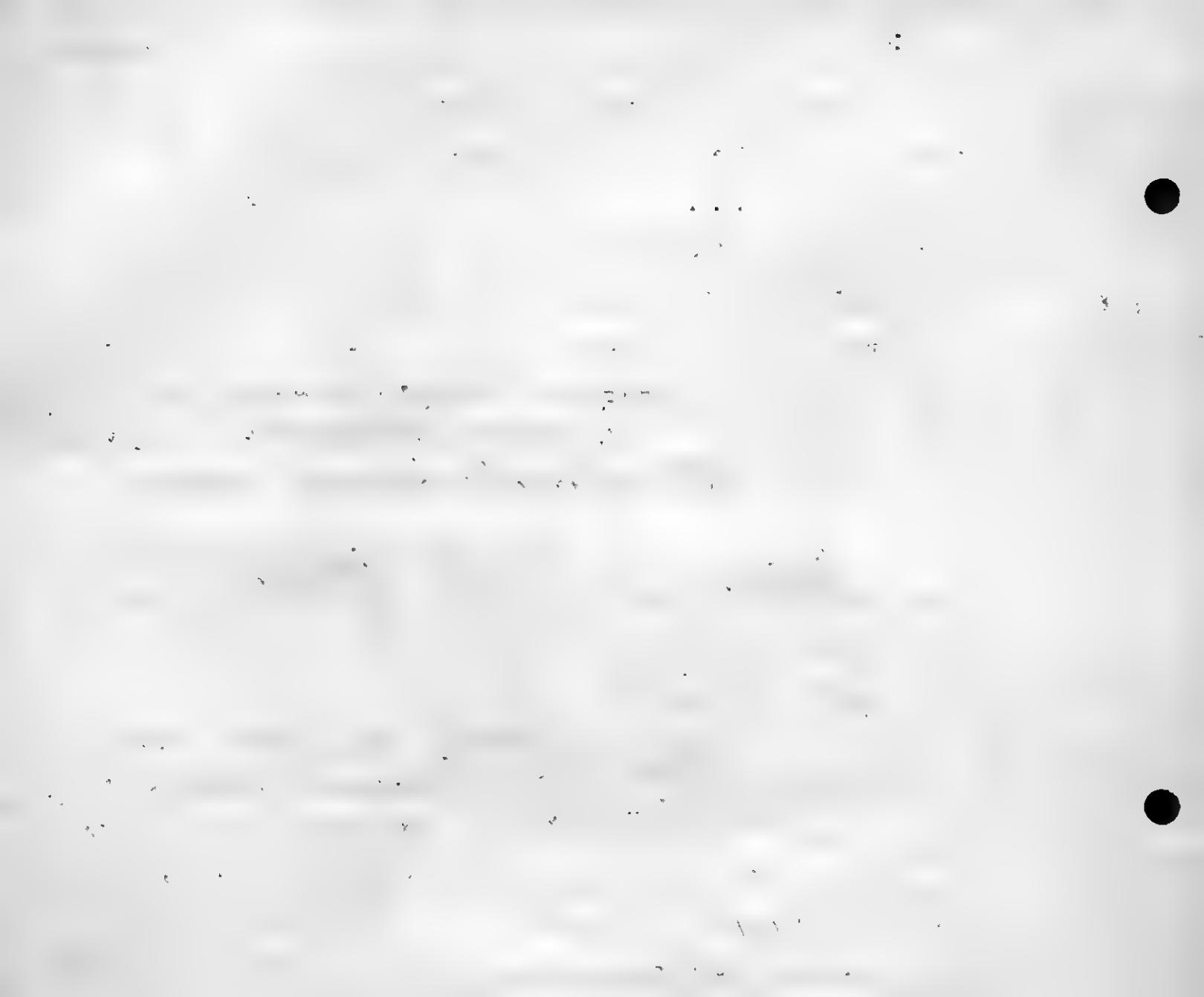
14141

14132

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Please sign and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Helen	Middle Ogreta	Last Seebacher	20. DATE OF DEATH Month 10	Day 22	Year 68	2b. HOUR 1301 M	
3. SEX Female	4. RACE White	5. DATE OF BIRTH August 1, 1901			6. AGE (In years lost birthday) 67 yrs.	IF UNDER MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore					
10. CITY OR TOWN OF DEATH Carney	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2903 Erie Ave			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Carney	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 2903 Erie Ave				
14. FATHER'S NAME First Harry	Middle Timmons	Last	15. MOTHER'S MAIDEN NAME First Minnie	Middle	Last Unverzagt			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO (If yes give war or dates of service) 213-12-4138A	17. INFORMANT Mr William H Seebacher	Address Same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> sudden due to, or as a consequence of <i>Atherosclerotic Cardiovascular Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) lost.								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Stroke 4-5 yr. previous</i>								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.	21f. LOCATION Street or R.F.D. No.	City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from <i>July 1, 1966, to Oct 1, 1968</i> , that (I) (we) last saw the deceased alive on <i>Oct 1, 1968</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (II) (we) did not view the body after death. <i>Paroxysmally Pronounced Dr JC Kyle</i>								
22b. SIGNATURE <i>Frank T Kasik Jr MD</i>		DEGREE ATTENDING PHYS	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>10/22/68</i>			
22d. PHYSICIAN'S NAME (Type) Frank T Kasik Jr MD		22e. ADDRESS 9005 Harford Rd Baltimore, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/24/68	23c. NAME OF CEMETERY OR CREMATORIAL Baltimore			23d. LOCATION (City or Town) Baltimore	(County) Maryland	(State)	
24. FUNERAL DIRECTOR Leonard J Ruck Inc Baltimore, Maryland				ADDRESS	25a. REC'D BY REGISTRAR DATE OCT 23 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14133

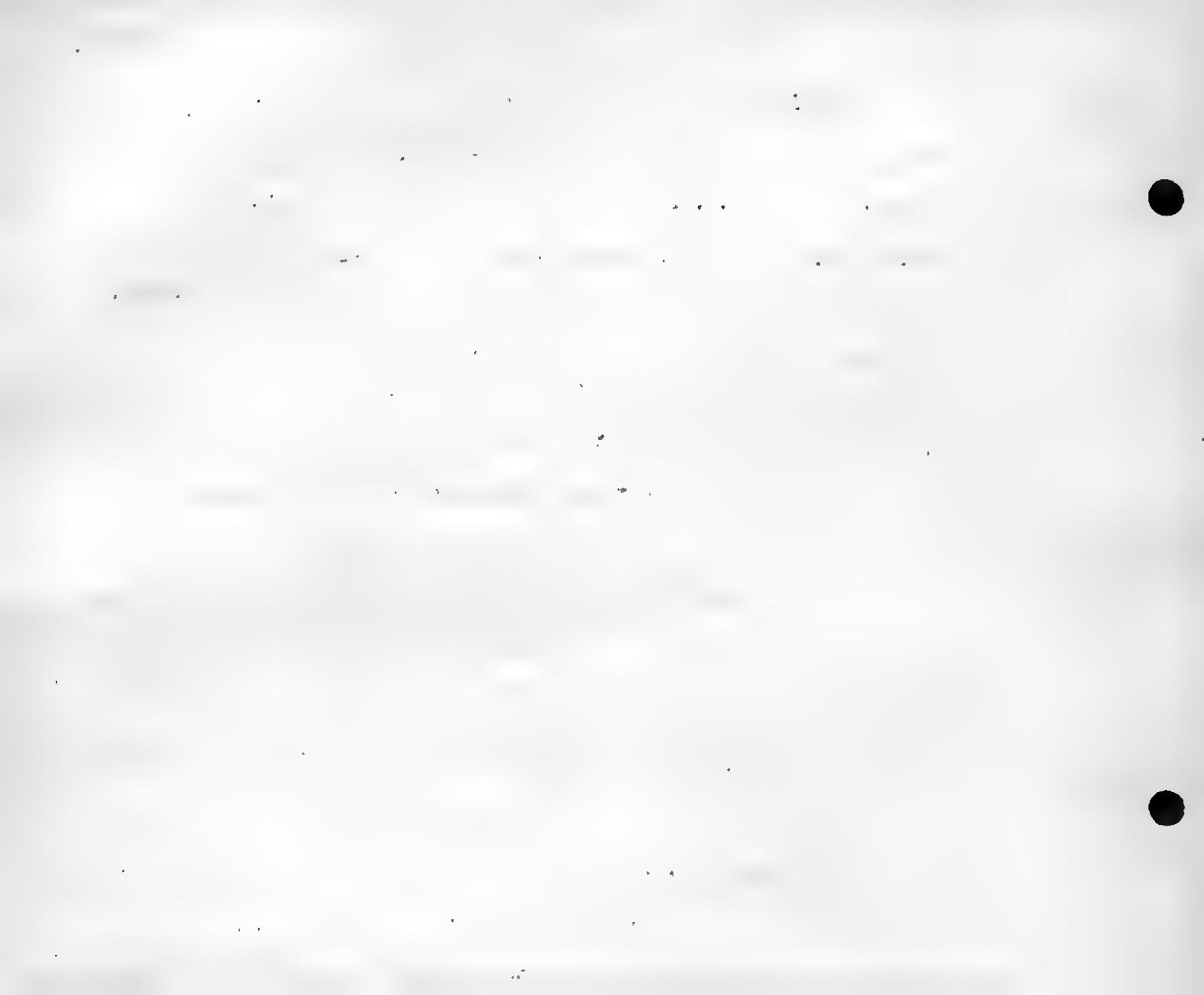
CERTIFICATE OF DEATH

14142

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon paper. If any event, within 24 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Hattie	Middle B	Last Shotts	2a. DATE OF DEATH Month 10 Day 1 Year 68	2b. HOUR 5:15 P.M.
3. SEX female	4. RACE white	5. DATE OF BIRTH 8-9-1890		6. AGE (in years last birthday) 78 yrs.	.F. UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 00 M N
7a. BIRTHPLACE (State or foreign country) Penna.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore		
10. CITY OR TOWN OF DEATH Towson, Md.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) homemaker			12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 8407 Harris Ave.		
14. FATHER'S NAME First JESSE V. SHOTTS	Middle 	Lost 	15. MOTHER'S MAIDEN NAME First Augusta V. Shawley	Middle 	Lost
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 199-24-9188	17. INFORMANT Family records	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure					
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Arteriosclerotic Cardio-Vascular Disease					
DUE TO, OR AS A CONSEQUENCE OF (b) (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)					
19a. DATE OF OPERATION 4/1		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) 		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No 	City or Town 	County
22a. I certify that (I) (this hospital) attended the deceased from 9-26-68 , 19 68 , to 10-1 , 19 68 , that (I) (we) last saw the deceased alive on 10-1- 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Beatriz T. Dizon</i>		DEGREE 	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22d. PHYSICIAN'S NAME (Type) Beatriz Dizon, M.D.		22e. ADDRESS 7620 York Road, Baltimore, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10-4-68	23c. NAME OF CEMETERY OR CREMATORIAL Moreland Memorial		23d. LOCATION (City or Town) Baltimore	(County) Md.
24. FUNERAL DIRECTOR C.F. EVANS & SON 8802 Harford road			ADDRESS	25a. REC'D BY REGISTRAR DATE OCT 4 1968	25b. REGISTRAR'S SIGNATURE <i>Charles J. Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14143

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)			First JENNIE	Middle SILVERMAN	Lost	2a. DATE OF DEATH Month 10 Day 25 Year 68	2b. HOUR 1:00 a.m.		
3. SEX Female		4. RACE White Hebrew	5. DATE OF BIRTH 3-17-69			6. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0	
7a. BIRTHPLACE (State or foreign country) Russia		7b. CITIZEN OF WHAT COUNTRY? Russia	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore			
10. CITY OR TOWN OF DEATH Catoonsville, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) domestic			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Reside before admission) STATE Md.		13b. COUNTY N	13c. CITY OR TOWN Balto.			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 120 S. Exeter St.		
14. FATHER'S NAME First Marcus Silverman		Middle 	Lost 	15. MOTHER'S MAIDEN NAME First Bessie Goldman			Middle 	Lost 	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 219-54-3476			17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure due to 411? DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic cardio- Conditions, if any, which gave rise to immediate cause (a). stopping the underlying cause lost. (c) vascular disease .									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town		County	State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept. 25, 1968 , to Oct. 25, 1968 , that <input checked="" type="checkbox"/> (I) (We) lost saw the deceased alive on Oct. 25, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (I) (We) (did) (did not) view the body after death.									22c. DATE SIGNED 10/25/68
22d. SIGNATURE Rafael H. Marin, M.D.		22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/27/68		23c. NAME OF CEMETERY OR CREMATORIUM Mt Carmel			23d. LOCATION (City or Town) Balto.		(County) Md.
24. FUNERAL DIRECTOR Sylvan S. Lewis & Son, Inc.		ADDRESS 9610 Reisterstown Rd			25a. REC'D BY REGISTRAR DATE OCT 29 1968			25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14144

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or the hospital or attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 from this certificate, sign page 3, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print) James Smiley Smith			First Middle Last	2a. DATE OF DEATH Month 10	Doy 21	Year 68	2b. HOUR 06:15
3. SEX Male		4 RACE White	S. DATE OF BIRTH 12/30/1887	6. AGE (In years last birthday) 80		YRS	F UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Penna		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 5201 Old Frederick Rd.		12a. USUAL OCCUPATION (Kind of work done during most of work no life even if retired) Railroad retiree		12b. KIND OF BUSINESS OR INDUSTRY Railroad	
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Balto.	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 5201 Old Frederick Rd. 21229		
14. FATHER'S NAME First Frederick G. Smith		Middle Last	15. MOTHER'S Maiden Name First Martha Smiley				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 705-09-1552	17. INFORMANT Mrs. James S. Smith, 5201 Old Frederick rd.	Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary edema						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Arteriosclerotic heart disease						Undetermined	
DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Senility							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING □ CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY Hour A.M. Month Doy Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from 10-21 , 19 68 , to 10-21 , 19 68 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE A. Bradley Daugherty, M.D.		DEGREE M.D.	ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 10-22-68	
22d. PHYSICIAN'S NAME (Type) A. Bradley Daugherty, M.D.		22e. ADDRESS 1264 Francise Avenue, 21227					
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE 10/24/68	23c. NAME OF CEMETERY OR CREMATORIAL Lorraine Mausoleum		23d. LOCATION (City or Town) Woodlawn, Maryland	(County)	(State)
24. FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave.,		ADDRESS 21229	25a. DEATH CERTIFIED BY Oct 23 1968		25b. JUDGE J. Daugherty judge	DATE	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14145

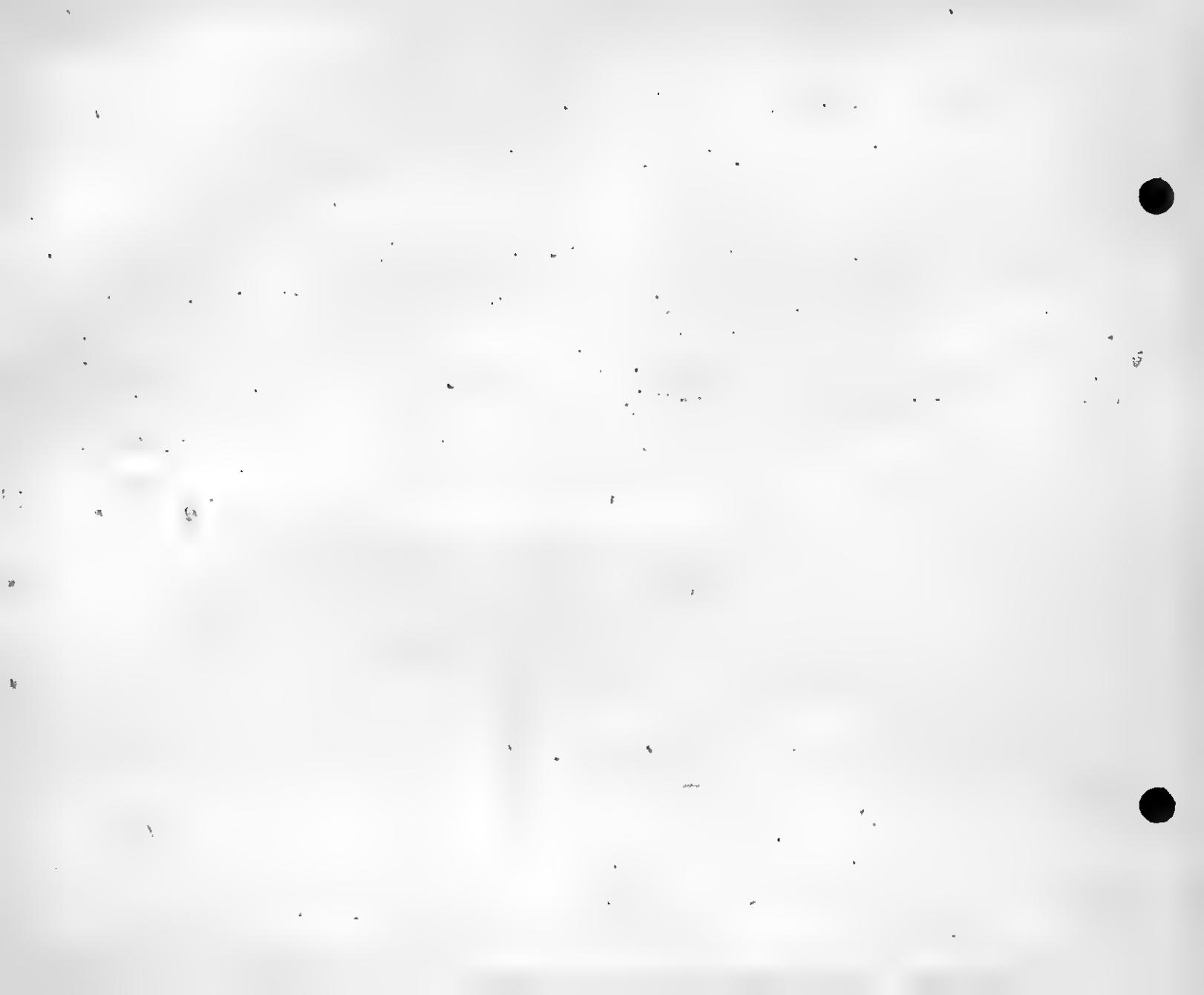
14136

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician's director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First <i>JOHN</i>	Middle <i>WILLIAM HAROLD SMITH</i>	Last <i>SMITH</i>	2a. DATE OF DEATH Month <i>10</i>	Day <i>19</i>	Year <i>68</i>	2b. HOUR <i>10</i>	
3. SEX <i>M</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>Feb. 22, 1896</i>		6. AGE (In years last birthday) <i>72</i>	YRS.	IE UNDER 1 YEAR <input type="checkbox"/>	IF UNDER 24 HRS MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	B MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Baltimore</i>				
10. CITY OR TOWN OF DEATH <i>Pikesville</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Pres. 204 McHENERY AVE.</i>		12a. USUAL OCCUPATION (kind of work done during most of working life, even if retired) <i>Baltimore Co.</i>		12b. KIND OF BUSINESS OR IND.STRY <i>Rds. Div.</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>Baltimore</i>	13c. CITY OR TOWN <i>Pikesville</i>	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER <i>204 McHENERY AVE.</i>				
14. FATHER'S NAME First <i>JOHN ROBERT SMITH</i>	Middle <i></i>	Last <i></i>	15. MOTHER'S MAIDEN NAME First <i>CARRIE A. BATES</i>	Middle <i></i>	Last <i></i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>yes</i>	16b. SOCIAL SECURITY NO. <i>517 071 929</i>	17 INFORMANT <i>unknown</i>	Address <i>Pikesville 8, Md. Mrs. ETTIE DELICE SMITH, 204 McHENERY</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>immediate 5 yrs approx</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4107</i> CORONARY THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF (b) <i>EMPHYSEMA</i> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. <i>9</i> Month <i>Dec</i> Day <i>10</i> Year <i>1967</i>	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) <i>while at work</i>					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <i></i>	21f LOCATION Street or R.F.D. No. <i></i>	City or Town <i></i>	County <i></i>	State <i></i>			
22a. I certify that (I) (this hospital) attended the deceased from <i>Dec 10, 1967</i> to <i>Sept 28, 1968</i> , that (I) (we) last saw the deceased alive on <i>9/28/68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Edwin L. Pierpont, M.D.</i>		DEGREE <i>EDWIN L. PIERPONT, M.D.</i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>10/19/68</i>		
22d. PHYSICIAN'S NAME (Type) <i>EDWIN L. PIERPONT, M.D.</i>		22e. ADDRESS <i>8204 LIBERTY Rd., Baltimore, Md.</i>						
23a. BURIAL/CREMATION REMOVAL (Specify) <i>Burial Oct. 23, 1968</i>	23b. DATE <i></i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>W. Hillside Cemetery</i>	23d. LOCATION (City or Town) <i>Baltimore</i>	(County) <i>Baltimore</i>	(State) <i>Md.</i>			
24. FUNERAL DIRECTOR <i>Frank J. Jewell, Pikesville, Md.</i>	ADDRESS <i></i>	25a. REC'D BY REGISTRAR <i></i>	25b. REG STRAY'S SIGNATURE <i>Charles Judge</i>					
		DATE <i>OCT 21 1968</i>						



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

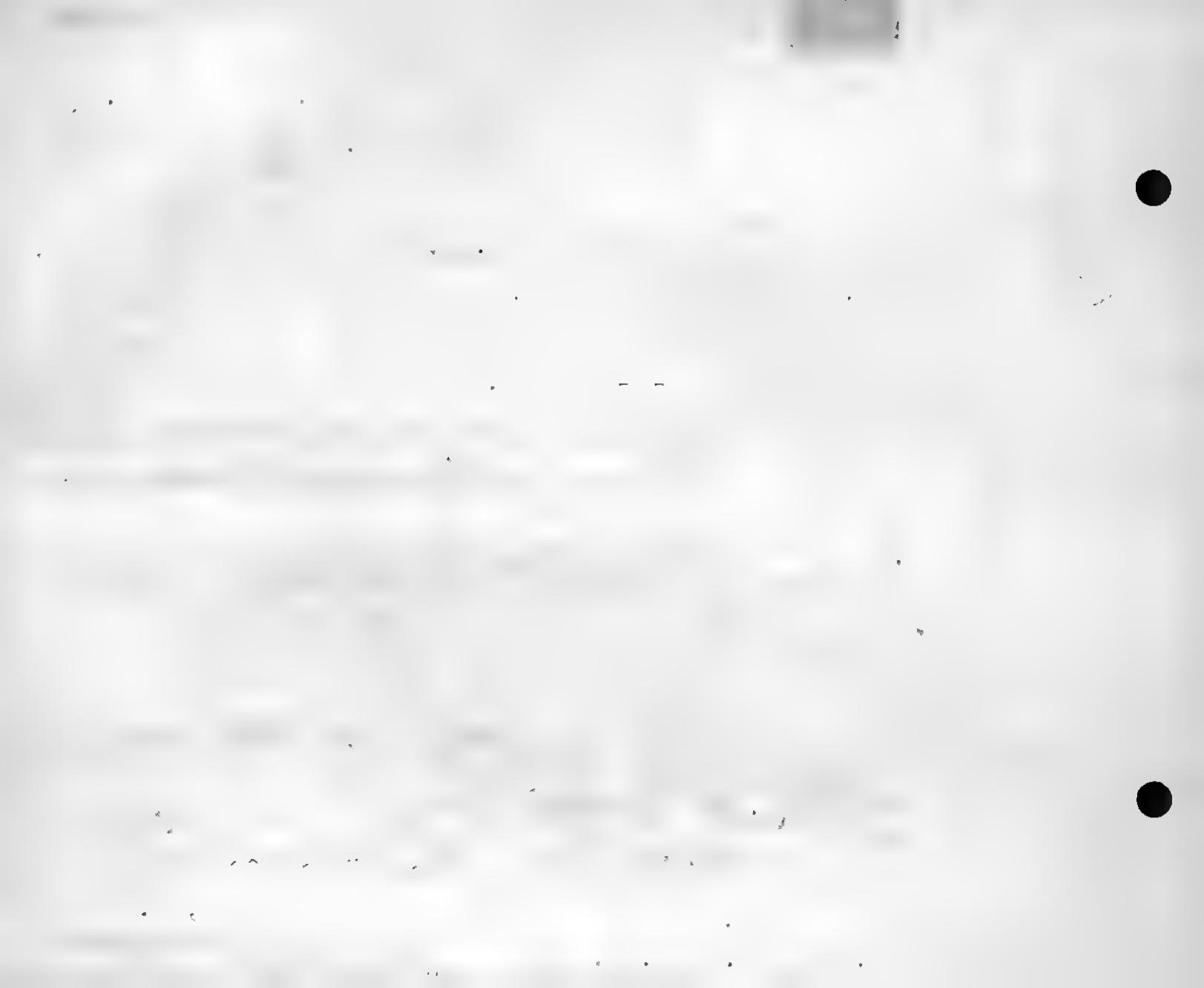
14146

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and returned by the hospital or attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours, after death.

1. DECEASED NAME (Type or print)		First EDWARD	Middle LEE	Last STALLINGS	2a. DATE OF DEATH Oct. Month 4 , Day 1968 .	2b. HOUR 3004 M
3. SEX Male	4. RACE White	5. DATE OF BIRTH March 3, 1896.		6. AGE (in years lost birthday) 72 YRS.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Baltimore			
10. CITY OR TOWN OF DEATH Parkville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 9648 Alda xx. Dr.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired guard	12b. KIND OF BUSINESS OR INDUSTRY Oil Co.	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.	13b. COUNTY Balte.	13c. CITY OR TOWN Balte.	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER 9648 Alda Drive		
14. FATHER'S NAME First John	Middle Stallings	Last	15. MOTHER'S MAIDEN NAME First Anna	Middle Boyer	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) W W 1	17. INFORMANT Mrs. Isabelle Heisterman	Address (Same)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cerebrovascular occlusion APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH one hour. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Generalized Atherosclerotic vascular Disease (b) Generalized Atherosclerotic vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Atherosclerotic vascular Disease DUE TO, OR AS A CONSEQUENCE OF						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Previous Cerebral Vascular occlusion 7 yrs ago.						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At Home, Farm, Street, Factory, Office Building, Etc.)		21f. LOCATION Street or R.F.D. No. 1000 HARFORD Rd	City or Town Baltimore	County Md.
22a. I certify that (I) (this hospital) attended the deceased from July 1968 to Oct 1968 , that (I) (we) last saw the deceased alive on July 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Okasik F. Kasik Jr.						
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 9000 HARFORD Rd		22c. DATE SIGNED 10/4/68.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/7/68.	23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National Cemetery		23d. LOCATION (City or Town) Baltimore, Md.	(County) Md.
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balte. Md. 21214		ADDRESS Leonard J. Ruck, Inc. Balte. Md. 21214	25a. REC'D. BY REGISTRAR OCT 4 1968		25b. REC'D. BY CLERK Okasik	



X 13 14133

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14147

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the attending physician or attending physician director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First Emma	Middle O'Tillie Staylor	Lost	2a. DATE OF DEATH Oct. 27, 1968	2b. HOUR 2:30 P.M.	
3. SEX Female		4. RACE Caucasian	S. DATE OF BIRTH Oct. 21, 1891	6 AGE (in years last birthday) 77	IF UNDERR 1 YEAR MONTHS DAYS	IF UNDERR 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 120 Overbrook Rd.		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMIT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 120 Overbrook Rd.		Md.
14. FATHER'S NAME First Henry		Middle Conrad	15. MOTHER'S MAIDEN NAME First Emma	Middle	Last Nobbe		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO 212-07-8561 B	17. INFORMANT Mr. Ernest Staylor	Address (Same)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) <i>Armenia</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
MEDICAL CERTIFICATION		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (the hospital) attended the deceased from <i>January 1968</i> to <i>October 1968</i> , that (I) (we) last saw the deceased alive on <i>Oct 26 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Charles E. Carr, M.D.</i>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>Oct 28/68</i>		
22d. PHYSICIAN'S NAME (Type) Charles E. Carr, M.D.		22e. ADDRESS 3900 N. Charles St.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/30/68.	23c. NAME OF CEMETERY OR CREMATORIUM Baltimore Cemetery	23d. LOCATION (City or Town) Baltimore, Maryland	(County)	(State)	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc., 5305 Harford Rd.		ADDRESS	25a. REC'D BY REGISTRAR DATE OCT 28 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

11130

14148

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil. Item 18 Give Pages 1, 2, 3, 4, 5 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form Page 3 which may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print)		First George	Middle T.	Last Steele	2a. DATE KNOWN OF DEATH ESTIMATED	Month October	Day 22	Year 1968	2b. HOUR 10 AM	
3 SEX <input checked="" type="checkbox"/> M	4 RACE <input checked="" type="checkbox"/> W	5 DATE OF BIRTH 7/24/1902	6 AGE (In years last birthday) 66 yrs	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month October			2d. HOUR 22	
7a. BIRTHPLACE (State or foreign country) N.Y.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore			Md.	
10 CITY OR TOWN OF DEATH Towson 21204		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) Retired-Proprietor			12b. KIND OF BUSINESS OR INDUSTRY Food		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Balto. 34	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 9101 Covered Bridge Rd.				
14. FATHER'S NAME Thomas		Middle Steele	Last	15. MOTHER'S MAIDEN NAME Edith	Middle	Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. WWII		17. INFORMANT Mrs. M. Annabelle Steele			ADDRESS (Same)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4104		Coronary Occlusion			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		(b) DUE TO, OR AS A CONSEQUENCE OF								
		(c) DUE TO, DR AS A CONSEQUENCE OF								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 42										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.			City or Town	County	State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Charles F. O'Donnell, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 10/23/68		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/26/68		23c. NAME OF CEMETERY OR CREMATORIAL Crumpton		23d. LOCATION (City or Town) Church Hill			(County)	(State) Md.
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Rd. Balto. 12, Md.		25a. REC'D BY REGISTRAR OCT 23 1968			25b. REGISTRAR'S SIGNATURE Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14149

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)	First	Middle	Lost	20. DATE OF DEATH	2b. HOUR
Nora		A	Style	10 Month 21 Day 68 Year	3:35 PM

3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS
Female	Cau	Feb 10, 1885	83 yrs.	MONTHS	DAYS HOURS MIN

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH
Maryland	U.S.A.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Baltimore

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	Greater Balto. Med. Center	Housewife	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	6309 Weidner Ave

14. FATHER'S NAME	First	Middle	Lost	15. MOTHER'S MAIDEN NAME	First	Middle	Lost
John	J	Sullivan		Margaret	J		?

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO	17. INFORMANT	Address
No	213-09-7226B	Mr William N Style	Same

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4107 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Arteriosclerotic cardiovascular disease. (b) DUE TO, OR AS A CONSEQUENCE OF (c)	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	Yes

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)
---------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------	---------------------------------------------------------------------------------

21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State
-------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------	--------------------------------------------------------------

22a. I certify that (I) (this hospital) attended the deceased from October 10, 1968, to October 21, 1968, that (I) (we) last saw the deceased alive on October 21, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	<input type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED
Rudiger Breitenecker			<input checked="" type="checkbox"/>		10/22/68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Rudiger Breitenecker, M.D.	6701 N. Charles Street

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION (City or Town) (County) (State)
Burial	10/25/68	New Cathedral	Baltimore, Maryland

24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Ruck Inc. Baltimore	Maryland	OCT 23 1968	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon paper from pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16141

14150

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Mary	Middle E.	Last Sullivan	2d. DATE OF DEATH Month 10	Day 19	Year 68	2b. HOUR 12:15
3. SEX Female	4. RACE White	5. DATE OF BIRTH 11-19-92			6. AGE (in years last birthday) 75	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	B MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore			12b. KIND OF BUSINESS OR INDUSTRY own home
10. CITY OR TOWN OF DEATH Randallstown, Md.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Balto. Co. Gen.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY own home		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.	13b. COUNTY Balto	13c. CITY OR TOWN Reisterstown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 406 S. Sacred Heart Rd.			
14. FATHER'S NAME John	First Unknown	Middle Candy	Last	15. MOTHER'S MAIDEN NAME Unknown	First Martha	Middle Simone	Last Hartlage, Legg
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or Unknown No	16b. SOCIAL SECURITY NO None	17. INFORMANT Mr. Emery Sullivan, 406 Sacred				Address	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause) (b) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4							
19a. DATE OF OPERATION MEDICAL CERTIFICATE ON		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING Cause of Death (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY OFFICE BUILDING ETC)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>DEPT 27, 1968</u> , to <u>OCT 19, 1968</u> , that (I) (we) last saw the deceased alive on <u>OCT. 19, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Fausto Q. Aquino, Jr.		DEGREE ATTENDING PHYS.	MED DIRECTOR	STAFF PHYS.	22c. DATE SIGNED 10/19/68		
22d. PHYSICIAN'S NAME (Type) FAUSTO Q. AQUINO SR		22e. ADDRESS BALTIMORE COUNTY GEN. HOSP.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		22f. DATE Oct. 23, 1968	23c. NAME OF CEMETERY OR Crematory Mount Royal Ridge Cemetery			23d. LOCATION (City or Town) Pylesville, Baltimore, Md.	(County) (State)
24. FUNERAL DIRECTOR Frank J. Kendall, Pikesville, Md.		ADDRESS	25a. REC'D. BY REGISTRAR DATE OCT 21 1968			25b. REGISTRAR'S SIGNATURE Charles Judge	



Item11 FilmG406 11/6/68 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

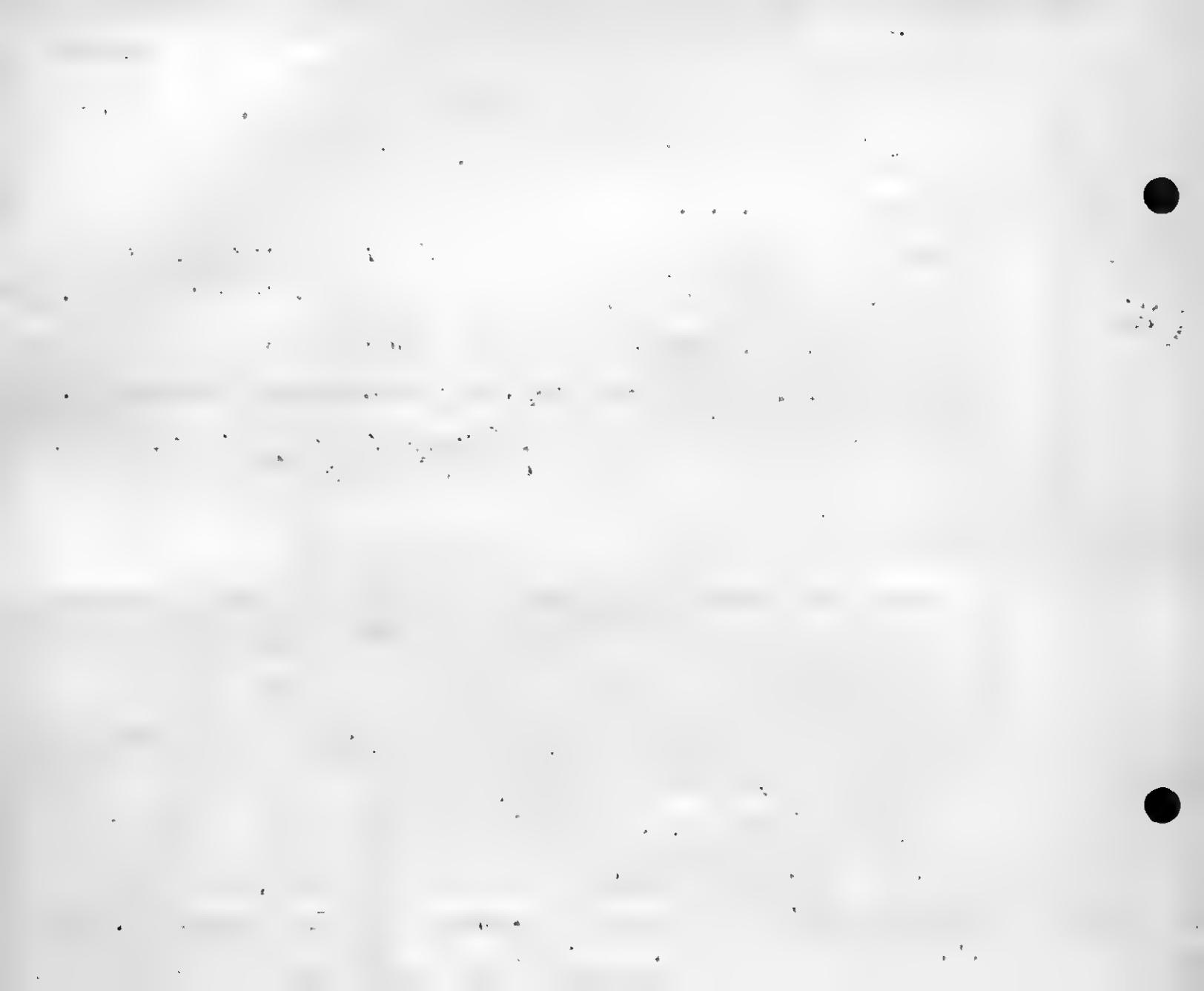
14151

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of the death.

1. DECEASED NAME (Type or print)	First J	Middle MURRAY	Last SWEENEY	2a. DATE OF DEATH Month OCT.	Day 30	Year 1968	2b. HOUR M				
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH AUG. 30, 1894		6. AGE (In years last birthday) 74	YRS	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	HOURS	MIN.		
7a. BIRTHPLACE (State or foreign country) BALTIMORE	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	9. COUNTY OF DEATH BALTIMORE								
10. CITY OR TOWN OF DEATH TOWSON	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 6811 Bellona Ave. 21212			12a. USUAL OCCUPAT. ON (Kind of work done during most of working life, even if retired) RETIRE-PRESIDENTMASTER LOAN			12b. KIND OF BUSINESS OR INDUSTRY				
13a. JSUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY BALTIMORE	13c. CITY OR TOWN TOWSON	13d. INS OF CITY LIMITS? YES	13e. STREET AND NUMBER 6811 BELLONA AVE.							
14. FATHER'S NAME THOMAS	First E.	Middle SWEENEY	Last	15. MOTHER'S MAIDEN NAME AGNES MURRAY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES	16b. SOCIAL SECURITY NO W.W. 1 216-05-45401	17. INFORMANT RS. JOSEPH L. MUTH	Address 207 HOLLEN RD.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hyper-tensive Cardiovascular Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 yrs.											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause { (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (if either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town		County		State			
22a. I certify that (I) this hospital attended the deceased from April 19, 60 , to Oct. 19, 68 , that (I) never last saw the deceased alive on 7 Oct. 1968 , and that in (my) never opinion death occurred on the date and hour and from the causes stated above, (I) never did never view the body after death.											
22b. SIGNATURE Wm. H. Kammer Jr. M.D.		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	<input type="checkbox"/>	22c. DATE SIGNED 10/31/68					
22d. PHYSICIAN'S NAME (Type) Wm. H. KAMMER JR.		22e. ADDRESS 6011 York Rd. 21212									
23a. BUR. AL. CREMAT. ON, REMOVAL (Specify) BURIAL		23b. DATE 11/2/68	23c. NAME OF CEMETERY OR CREMATORIAL NEW CATHEDRAL		23d. LOCATION (City or Town) BALTIMORE, MD.		(County)		(State)		
24. FUNERAL DIRECTOR H.W. TEARS & SON		ADDRESS 805 N. CALVERT ST.	25a. REC'D BY REGISTRAR DATE NOV 4 1968			25b. REGISTRAR'S SIGNATURE Charles Judge					



FOR STATE
HEALTH DEPT.

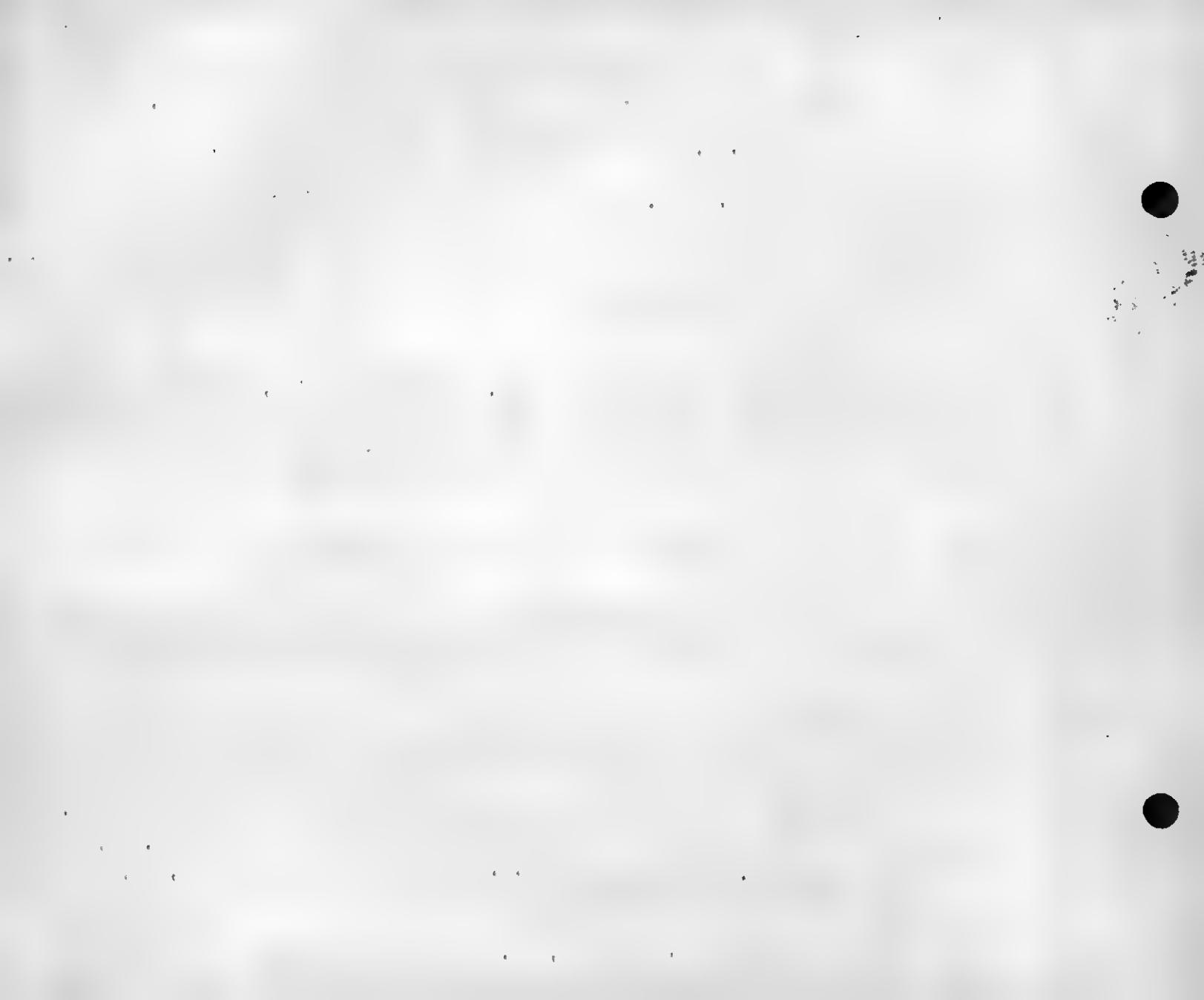
13143
7
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in the space provided. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Boe 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14152

1 DECEASED NAME (Type or Print)	First Andrew	Middle G.	Last Swingler	2a DATE KNOWN OF ESTI DEATH MATED	Month Oct. 21	Day 1968	Year	2b HOUR M
3 SEX Male	4 RACE White	5 DATE OF BIRTH Oct. 3, 1896	6 AGE (In years last birthday) 72	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	HOURS	MIN.	2d HOUR M
7a BIRTHPLACE (State or foreign country) Maryland	7b CITIZEN OF WHAT COUNTRY? U. S. A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Baltimore	2c DATE PRONOUNCED DEAD Month October	Day 21	Year 1968	Md	
10 CITY OR TOWN OF DEATH Dundalk	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 9 Oakwood Road	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Machine Shop	12b KIND OF BUSINESS OR INDUSTRY Patapsco R.R.					
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland	13b COUNTY Baltimore	13c CITY OR TOWN Dundalk	13d. INSIDE CTY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER 9 Oakwood Road				
14 FATHER'S NAME First Louis	Middle	Last Swingler	15 MOTHER'S MAIDEN NAME First Katherine	Middle	Last Kelley			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	16b SOCIAL SECURITY NO WVI	17. INFORMANT (Wife) Mrs. Margaret Swingler, 9 Oakwood Road	ADDRESS Dundalk, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Acute Coronary Occlusion				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HCV D (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 14100								
19a. DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town	County State	
22o. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Theodore Patterson</i>		EXAMINER'S NAME (Type) Theodore C. Patterson		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> 3724 Dundalk Ave. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 22b DATE SIGNED Oct. 22, 1968 DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) Dundalk, Md. 21222		
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 10/24/68		23c NAME OF CEMETERY OR CREMATORIAL Oak Lawn Cemetery		23d LOCATION (City or Town) (County) (State) Baltimore, Maryland		
24 FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave.		ADDRESS Dundalk, Md.		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE Charles Judge		
VR A15ME 10M REV 1/68				DATE OCT 24 1968				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14153

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)		First Anthony	Middle N. Tallarico	Lost TALLARICO	2a. DATE OF DEATH Month October	Doy 6	Year 1968	2b. HOUR 1:30 p.m.	
3. SEX male		4. RACE white		5. DATE OF BIRTH Sept. 1, 1906.		6. AGE (In years last birthday) 62 yrs		IF UNDER 1 YEAR MONTHS DAYS IF JUNIOR 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Penns.		7b. CITIZEN OF WHAT COUNTRY? U. S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore			
10 CITY OR TOWN OF DEATH Catonsville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) clerk		12b. KIND OF BUSINESS OR INDUSTRY Insurance			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13c CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2035 North Lakewood Ave.			
14. FATHER'S NAME First Salvatore		Middle Tallarico	Lost Vincenza	15. MOTHER'S MAIDEN NAME First Anania					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO (If yes give war or dates of service) None		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Pulmonary embolism, bilateral						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min.	
450 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 4 X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (1) (this hospital) attended the deceased from April 11, 1968, to Oct. 6, 1968, that (1) (we) last saw the deceased alive on Oct. 6, 1968, and that in (no) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) (did not) view the body after death.									
22b. SIGNATURE <i>Anthony J. Young, M.D.</i>		22c. DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/>		MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/10/68.		23c. NAME OF CEMETERY OR CREMATORIAL Holy Redeemer Cem.		23d. LOCATION (City or Town) Baltimore, Md.		(County) (State)	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		ADDRESS Leonard J. Ruck, Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR OCT 8 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



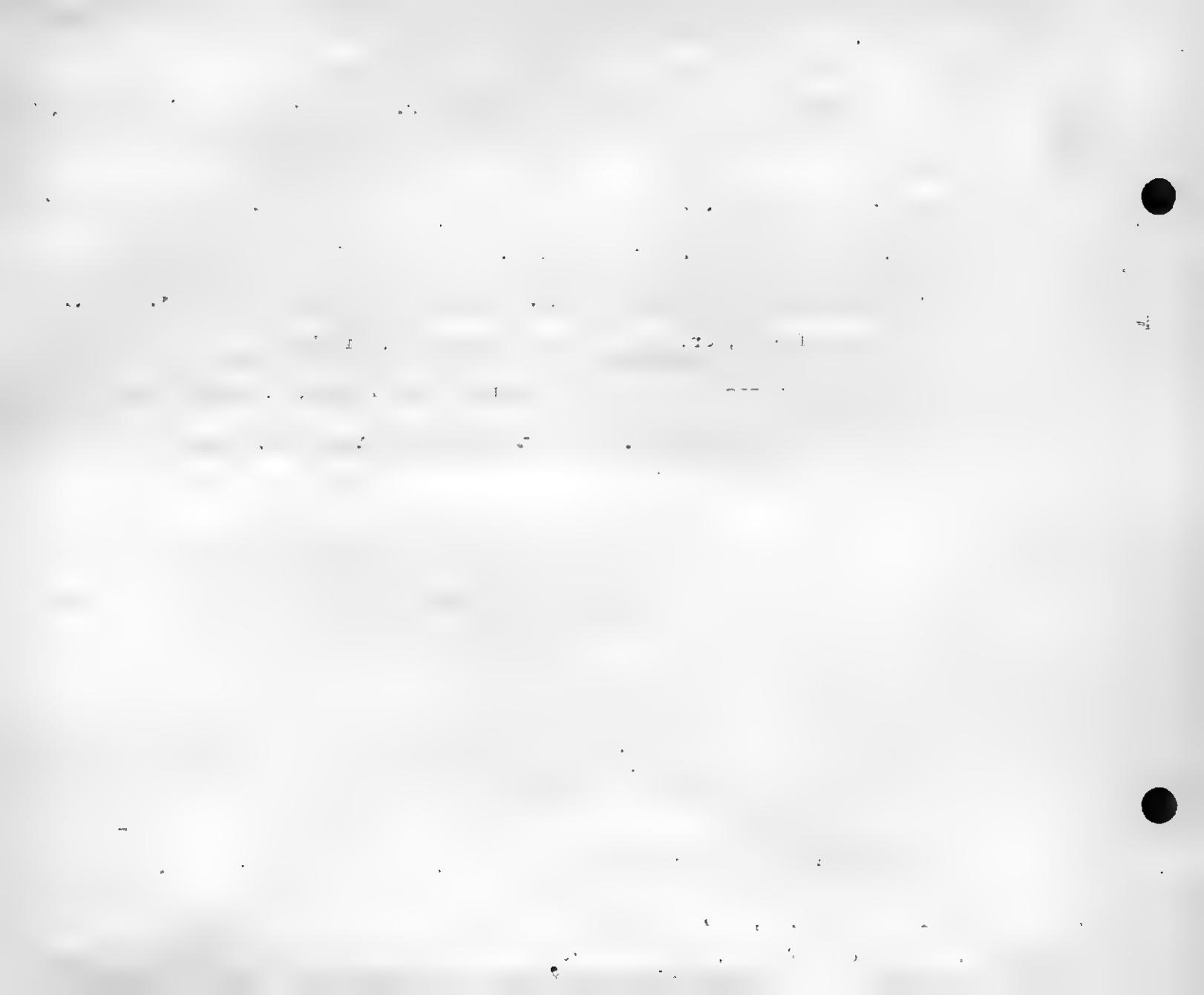
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

PAGE 4 may be retained by the hospital or attending physician.
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH**

14154

1. DECEASED NAME (Type or print)	First Robert	Middle Lee	Last Taylor Jr.	2a. DATE OF DEATH Month October	Day 19	Year 1968	2b. HOUR 5.30PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH 8-26-02			6. AGE (in years last birthday) 66	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	9. COUNTY OF DEATH Baltimore				
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Sales			12b. KIND OF BUSINESS OR INDUSTRY Plumbing		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission). STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Towson	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER 22 East Seminary Ave., Md.			
14. FATHER'S NAME First Robert Lee Taylor, Sr.	Middle	Last	15. MOTHER'S MAIDEN NAME Frances E. Mitchell				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO.	17. INFORMANT Frances Duke Taylor, Same as # 13			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extensive Carcinomatosis, primary left lung DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from 10/14/1968 , to 10/19/1968 , that <input type="checkbox"/> (we) lost saw the deceased alive on 10/19/1968 , and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> (we) (did) <input type="checkbox"/> view the body after death.							
22b. SIGNATURE <i>Christina Feleciano, M.D.</i>		22c. DEGREE M.D.	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED 10-19-68	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 7620 York Rd., Towson, Md. 21204					
23a. BURIAL, CREMAT. ON, REMOVAL (Specify) Burial	23b. DATE Oct. 23, 1968	23c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cemetery		23d. LOCATION (City or Town) Baltimore, Md.	(County)		(State)
24. FUNERAL DIRECTOR Wm. Cook-Brooks	ADDRESS 1050 York Road Towson, Md. 21204	25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	DATE OCT 22 1968		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14155

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, then please remove carbon paper. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Then please remove carbon paper. Within 72 hours after death.

1. DECEASED NAME (Type or print)	First William	Middle M.	Last TAYLOR	2a. DATE OF DEATH Month October 11 Day Year 1968	2b. HOUR A.M. 7:45
3. SEX Male	4 RACE White	5. DATE OF BIRTH June 23-1902		6 AGE (In years last birthday) 66 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Baltimore		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY Butcher	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 541 Benninghaus Rd. #21212	Md.
14. FATHER'S NAME Charles R. Taylor	15. MOTHER'S MAIDEN NAME Alice Bristow				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes	16b. SOCIAL SECURITY NO. Mar 11	17. INFORMANT Wife: Bertha B. Taylor same	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive myocardial infarction 4100 DUE TO, PROLONGED coronary thrombosis.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4101					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22o. I certify that (I) (this hospital) attended the deceased from 10-5-1968, to 10-11-1968, that (I) (we) last saw the deceased alive on 10-11-1968, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Ines Cilliani	DEGREE ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED October 11, 1968	
22d. PHYSICIAN'S NAME (Type) Ines Cilliani, M.D.	22e. ADDRESS 7620 York Road, Towson, Md. 21204				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Oct. 15 & 68	23c. NAME OF CEMETERY OR CREMATORIAL Harmony Grove Baptist Church Urbana, Va.	23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR Eugenia K. Seitz 5209 York Road Seitz Funeral Home Baltimore, Md. 21212	ADDRESS Balto. Md.	25a. REC'D BY REGISTRAR DATE OCT 14 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14156

1. DECEASED-NAME (Type or print)		First John	Middle A.	Last THIEL Sr.	2a DATE OF DEATH Month 10 Day 8 Year 1968	2b. HOUR 12:p.m.
3. SEX Male		4. RACE White		S. DATE OF BIRTH May 13, 1882	6. AGE (in years lost birthday) 86 yrs	IF UNDER 1 YEAR MONTHS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Baltimore,	Md.
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Ret. Wholesale Produce	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES	13e. STREET AND NUMBER 1243 Halstead Rd.
14. FATHER'S NAME First Hall		Middle 	Last Thiel	15. MOTHER'S MAIDEN NAME First Camille	Middle 	Last Scheubert
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 212-03-8907		17. INFORMANT Charles F. Thiel	Address Cockeysville Malcolm Circle	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Old and acute and probable myocardial infarction DUE TO, OR AS A CONSEQUENCE OF secondary to severe coronary aterio- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sclerosis DUE TO, OR AS A CONSEQUENCE OF (c)						
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION 9/16/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Urinary obstruction		20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from 8/25/68 , to 10/8/68 , that <input type="checkbox"/> (we) last saw the deceased alive on 10/8/68 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.						
22b. SIGNATURE Samuel R. Jr., MD.		DEGREE ATTENDING PHYS	<input type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 10-8-68	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 7620 York Rd., Towson, Md. 21204				
23a. BURIAL, CREMATON, REMOVAL (Specify) Burial		23b. DATE 10/12/68	23c. NAME OF CEMETERY OR CREMATORIUM New Cathedral Cem.		23d. LOCATION (City or Town) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. Baltimore, Md.		ADDRESS	25. RECEIVED BY REGISTRAR OCT 11 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be ~~printed~~ within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

NO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



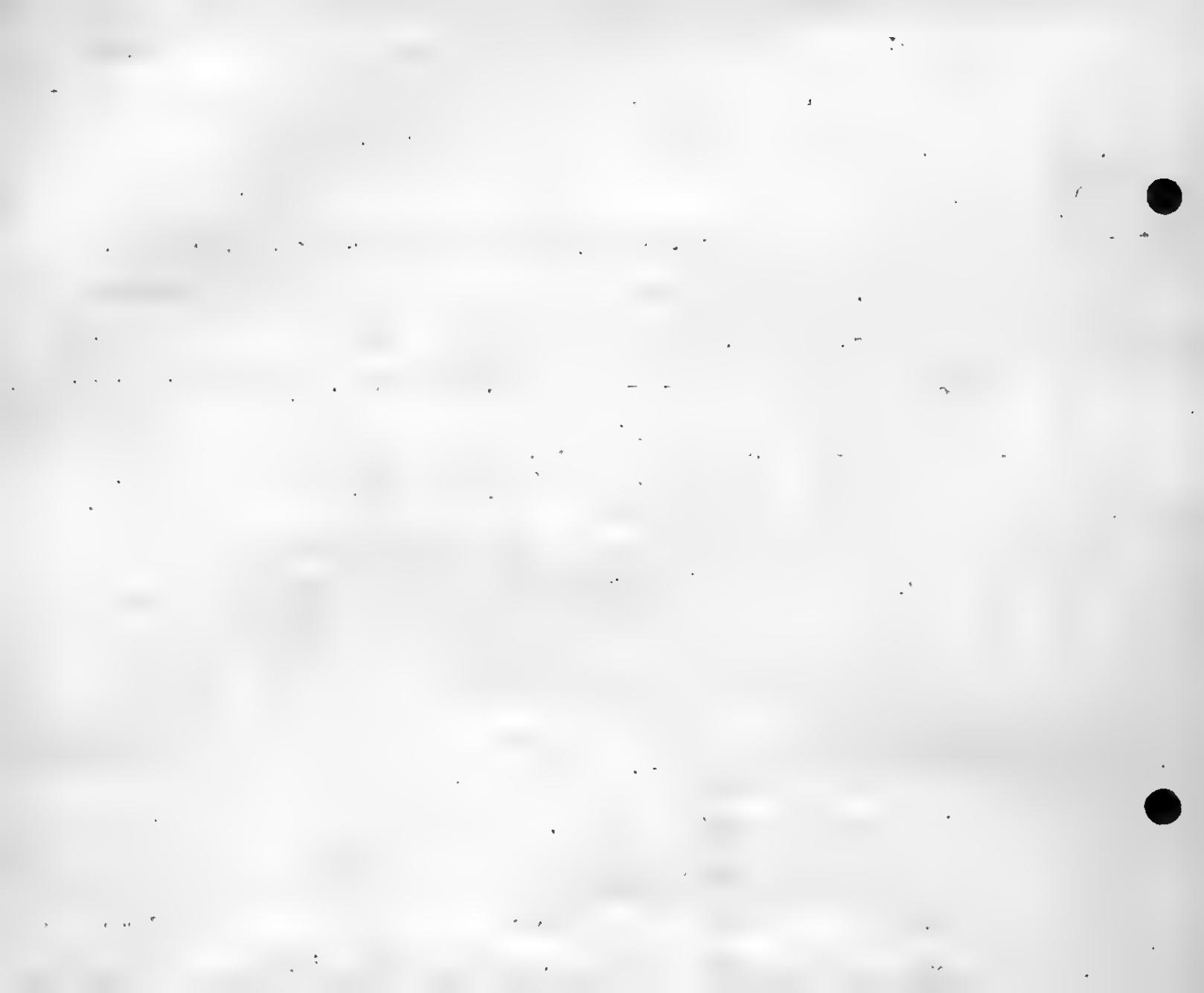
CERTIFICATE OF DEATH

14157

1. DECEASED-NAME (Type or print)		First Bernard	Middle H.	Lost Thompson Sr.	2d. DATE OF DEATH Month October 28, 1968	2b. HOUR 5:15 P.M.			
3. SEX <input checked="" type="checkbox"/> Male		4 RACE white		S. DATE OF BIRTH June 24, 1908	6 AGE (In years lost/birthday) 80	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. HOURS 0	MD. M.N.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore				
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 8204 Thornton Road 21204			12a. USUAL OCCUPATION (Kind of work done during last of working life, even if retired) Vice Pres. Mt. Vernon Mills			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 8204 Thornton Road			
14. FATHER'S NAME First Joseph		Middle B.	Last Thompson	15. MOTHER'S MAIDEN NAME Anna		Middle lost Miller			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 212-09-0061		17. INFORMANT Mrs. Elizabeth R. Thompson		Address 8204 Thornton Rd.			
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Acute myocardial infarct</u> 4100 DUE TO, OR AS A CONSEQUENCE OF <u>atherosclerotic</u></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> <u>spait & disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)</p> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min 10 yrs</p>									
<p>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)</p> <p>4200 <u>Cerebral Thrombosis (one yr ago)</u></p>									
19a. DATE OF OPERATION 4/27/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No	City or Town	County	State		
<p>22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 5, 1967</u>, to <u>Oct 28, 1968</u>, that (I) (we) last saw the deceased alive on <u>Oct 21, 1968</u>, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</p>									
<p>22b. SIGNATURE <u>Walter R. Welzant, M.D.</u></p>									
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS Dr. Walter R. Welzant		22c. DATE SIGNED Oct 29, 1968					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/30/68	23c. NAME OF CEMETERY OR CREMATORIAL Druid Ridge			23d. LOCATION (City or Town) Balto.		(County) Md.	(State)
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home		ADDRESS 6500 York Rd. #21212		25a. REC'D BY REGISTRAR DATE NOV 1 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

NO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in ~~at the funeral~~, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 14149						14158
1. DECEASED NAME (Type or print)	First Charles M.	Middle Thompson	Lost	2a. DATE OF DEATH Month October Year 1968	2b. HOUR 6:30 P.M.	
3. SEX Male	4. RACE White	S. DATE OF BIRTH Feb. 18, 1884	6. AGE (In years lost birthday) 84 yrs.	F. UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore,	Md		
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holly Hill Manor	12a. USJAL OCCUPATION (Kind of work done during most of working life, even if retired) Machinist	12b. KIND OF BUSINESS OR INDUSTRY B&D			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Stoneleigh	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 632 Regester Ave.		
14. FATHER'S NAME Kilby	First Middle Thompson	15. MOTHER'S MAIDEN NAME Nannie	Middle	Lost	Taylor	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT F. Osborne Wilhelm	Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Thrombosis Arteriosclerosis			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 hrs			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)						
MEDICAL CERTIFICATION						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from June 10, 1964, to Oct 4, 1968, that (I) (we) last saw the deceased alive on Oct 4, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Laurence C. Post M.D.	DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 10/15/68		
22d. PHYSICIAN'S NAME (Type) LAURENCE C. Post	22e. ADDRESS 6805 York Rd - Baltimore 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/7/68	23c. NAME OF CEMETERY OR CREMATORIAL Druid Ridge Cemetery	23d. LOCATION (City or Town) Baltimore, Maryland	(County)	(State)	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson 1050 York Rd. 21204	ADDRESS	25a. REC'D BY REGISTRAR DATE OCT 8 1968	25b. REGISTRAR'S SIGNATURE Charles Judge			



14150

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14159

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

NAME OF DECEASED
(Type or Print)

VINTON. WALTER TUCKER

2. DATE AND HOUR OF DEATH

Oct. 28, 1968

10:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

BALTIMORE COUNTY

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

6305 Banbury Road

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore Towson

D. INSIDE CITY LIMITS?

YES NO

E. STREET AND NUMBER

6305 Banbury Road

5. SEX

6. RACE

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

July 10, 1883

9. AGE (in years
last birthday)

85

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10. USUAL OCCUPATION (Give kind of work
one during most of working life, even if retired)

Bakery Salesman

11. KIND OF BUSINESS OR INDUSTRY

retired

11. BIRTHPLACE (State or foreign country)

Anne Arundel Co, Md.

12. CITIZEN OF WHAT COUNTRY

USA

13. FATHER'S NAME

John Thomas Tucker

14. MOTHER'S MAIDEN NAME

Alice Ridgeway

5. Was Deceased Ever in U. S. Armed Forces?
Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

216-09-2402 Mrs. Elizabeth Gay; 6305 Banbury Rd.

ADDRESS

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:Arteriosclerotic Cardio-
vascular Disease(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(B) DUE TO, OR AS A CONSEQUENCE OF

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (All stating the
UNDERLYING CONDITION last).22. I certify that (I) (this hospital) attended the deceased from Oct. 28th May 1957 to Oct. 28, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.

23A. SIGNATURE

*M. K. Quinn MD*Attending
Phys.

DEGREE

Med.
Director

□

Staff
Phys.

□

23B. DATE SIGNED

*10/29/68*23C. PHYSICIAN'S
NAME (Type)

Dr. M. Kevin Quinn

Degree

23D. ADDRESS

1927 York Road, Towson 4, Md.

24A. BURIAL CREMATION, 24B. DATE
REMOVAL (Specify)

10/31/68

24C. NAME OF CEMETERY OR CREMATORIUM

Parkwood Cemetery

24D. LOCATION

Baltimore, Md.

(City, town, or county)

(State)

burial

removal

cremation

transit

permit

service

date

time

place

location

address

name

initials

signature

date

year

month

day



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14160

1. DECEASED-NAME (Type or print)			First	Middle	Last	20. DATE OF DEATH Month	Doy	Year	2b. HOUR						
			WILLIAM MCKINLEY TURNER			10 - 28 - 1968			2 P. M.						
3. SEX		4. RACE	S. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN							
M		Negro	4/22/1904			64 yrs.									
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH									
Virginia		U.S.A.				Baltimore County,			Md						
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY							
Mount Wilson		Mt. Wilson State Hosp.			Packster										
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER									
MD		Montgomery Kensington				4005 Pleyers Mill Rd.									
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last							
		Marshall	Turner		Cornelia			Crawford							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO. , (If yes give war or dates of service)			17. INFORMANT			Address							
		579-09-5110			Records, Mt. Wilson State Hospital										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) ARTERIOSCLEROSIS CEREBROVASCULAR 4/22/68 DISEASE DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (c) DUE TO, OR AS A CONSEQUENCE OF (d)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				YES				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.			City or Town		County	State				
22a. I certify that (I) (this hospital) attended the deceased from 10/22/68 , to 10/28/68 , that (I) (we) last saw the deceased alive on 10/22/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE William Newcomer										22c. DEGREE	ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input checked="" type="checkbox"/> STAFF PHYS	<input type="checkbox"/>	DATE SIGNED
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS					
William Newcomer, M.D.										Mount Wilson, Maryland					
23a. BURIAL, CREMATION, REMOVED (TYPE)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION (City or Town)		(County)	(State)					
BURIAL		11-2-68		PINEY ROCK CEMETERY			NELSON COUNTY, VIRGINIA								
24. FUNERAL DIRECTOR		ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
		ROBERT L. SNOWDEN						NOV 6 1968							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1b. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14161

1 DECEASED NAME (Type or Print)	First	Middle	Last	20. DATE KNOWN OF ESTI DEATH MATED <input checked="" type="checkbox"/>	Month	Day	Year	2b HOUR		
VICENT C. VACEK, JR.				10	11	1968	5:14pm			
3. SEX	4 RACE	5. DATE OF BIRTH	6 AGE (in years last birthday)	7 IF UNDER 1 YEAR MONTHS	8 IF UNDER 24 HRS DAYS	9 HOURS	10 MIN.	2d. HOUR		
Male	White	10/13/38	29 YRS							
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH							
Balto. Md.	U.S.A.		Balto.							
10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY							
Towson	St. Joseph Hospital	Draftsman-Koppers-Glen Arm								
13a USUAL RESIDENCE (Where deceased lived, if institution before admission) STATE	13b. COUNTY	13c CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER						
Md.		Balto.		3417 E. Northern Pkwy.						
14 FATHER'S NAME	First	Middle	Last	15 MOTHER'S MAIDEN NAME	First	Middle	Last			
Vincent C. Vacek, Sr.				Marie Hajek						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown)	16b. SOCIAL SECURITY NO (If yes give war or dates of service)	17 INFORMANT	ADDRESS							
	217-34-3547	Betty L. Vacek (nec McLain) wife, above								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY										
IMMEDIATE CAUSE (a) Craniocerebral injuries										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b)										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year HOUR <input checked="" type="checkbox"/> 4:40 PM		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)			Subject struck by station wagon			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Rd.		21f. LOCATION Street or R.F.D. No.			City or Town County State			
				2900 Cub Hill Rd. Balt.			Baltimore, Md.			
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		Ronald N. Kornblum, M.D.							CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)									ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
									22b. DATE SIGNED	
									October 12, 1968	
23a BURIAL CREMATION, REMOVAL(Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORIAL	23d LOCATION (City or Town)	(County)	(State)	ADDRESS(Street, city, town, or county)				
Burial	10/15/68	Holy Redeemer Cem.	Baltimore, Md.							
24 FUNERAL DIRECTOR Schimunek Funeral Home, Inc.	ADDRESS 3331 Brehms Lane			25a REC'D BY REG STAR	25b. REGISTRAR'S SIGNATURE					
				DATE OCT 15 1968	Charles Judge					
VR A15ME 151 10M REV 1/68										



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

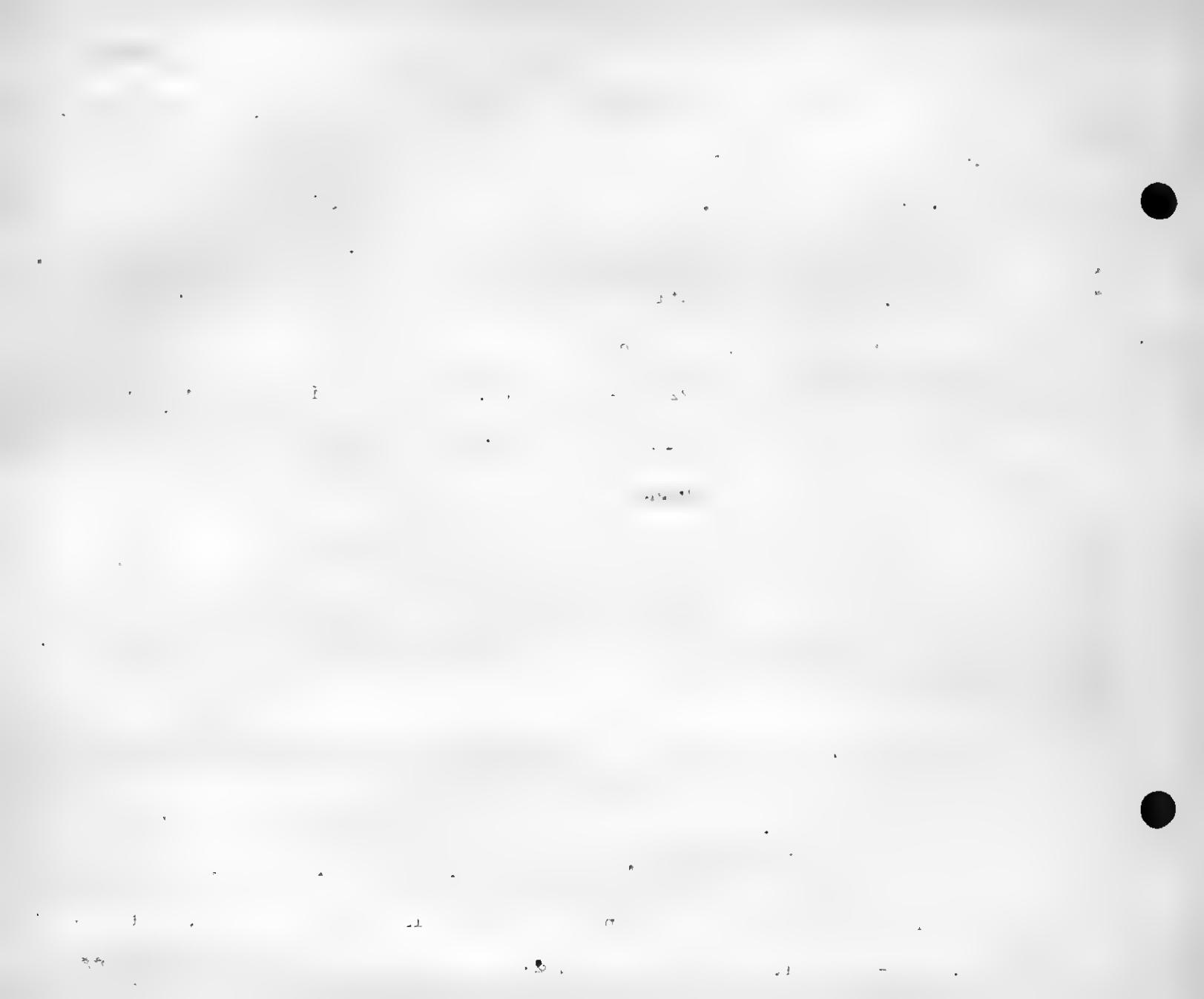
16153

14162

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If you may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First John	Middle Milton	Last Vincent	2a. DATE OF DEATH Month 10	Day 8	Year 1968	2b. HOUR 8:50 A.M.
3. SEX Male		4. RACE White		S. DATE OF BIRTH January 13, 1924	6. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Baltimore,			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Engineer		12b. KIND OF BUSINESS OR INDUSTRY Self empl.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Timonium	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER 115 Northwood Dr.		
14. FATHER'S NAME First Charles		Middle M.	Last Vincent	15. MOTHER'S MAIDEN NAME First Edna		Middle Morlock	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> Yes, no, or unknown WWII		16b. SOCIAL SECURITY NO. 220-18-4134		17. INFORMANT Mrs. Bernita R. Vincent		Address 115 Northwood Dr.		
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive gastro-intestinal hemorrhage APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) advanced portal cirrhosis</p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c)</p>								
<p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No	City or Town		County	State
<p>22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10/7/68, to 10/8/68, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10/8/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (I) <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (did) <input checked="" type="checkbox"/> (did not) view the body after death.</p>								
22b. SIGNATURE Ines Cilliani		DEGREE	ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 10/8/68		
22d. PHYSICIAN'S NAME (Type) Ines Cilliani, M.D.		22e. ADDRESS 7620 York Rd., Towson, Md. 21204						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/11/68	23c. NAME OF CEMETERY OR CREMATORIAL Dulaney Valley Memorial		23d. LOCATION (City or Town) Cockeysville, Balto. Maryland		(County)	(State)
24. FUNERAL DIRECTOR Wm. Cook-Brooks		ADDRESS Towson 1050 York Rd. 21204		25a. REC'D BY REGISTRAR OCT 9 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



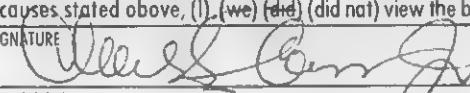
19
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

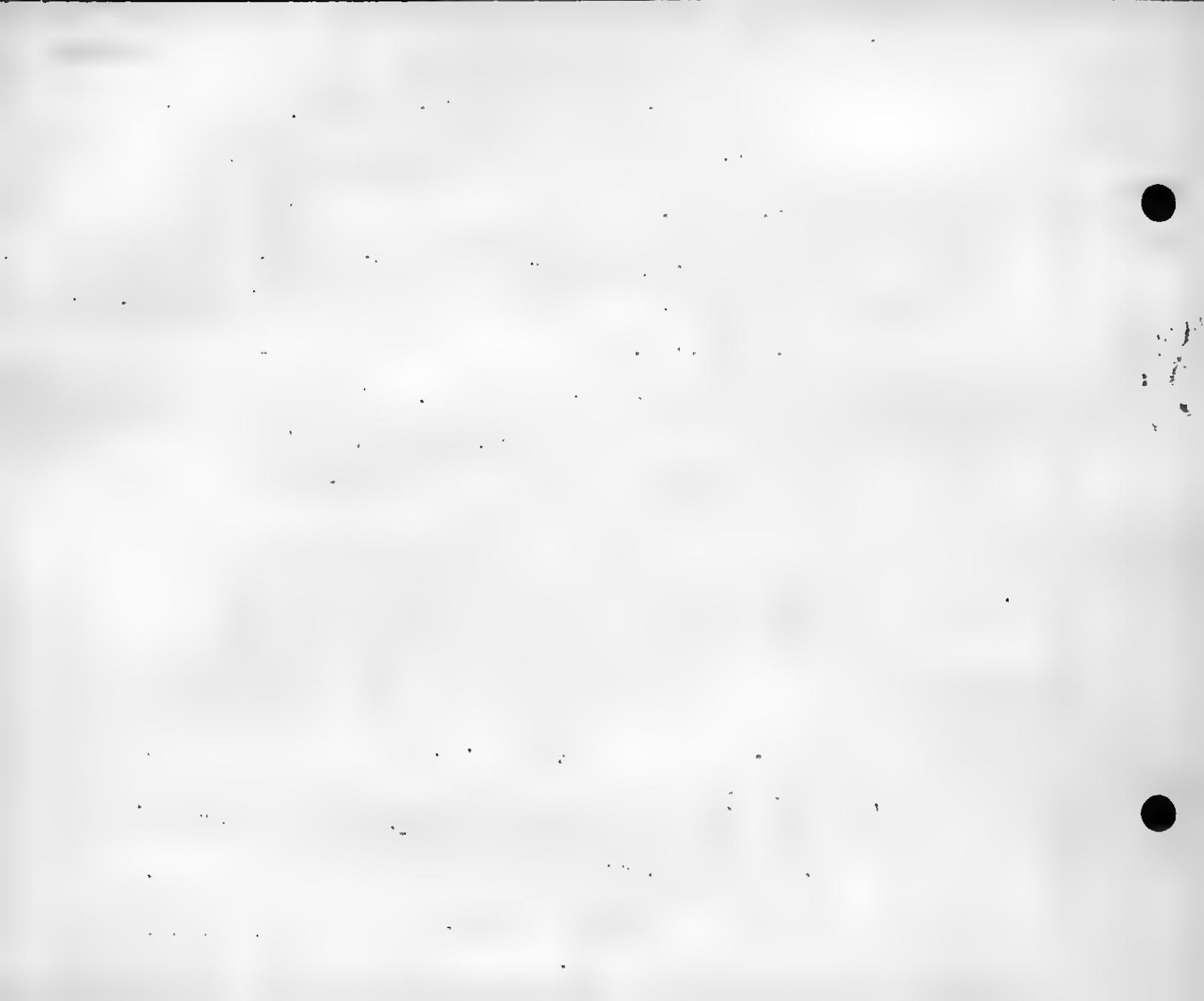
Page 4 may be retained by the hospital or attending physician.
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages and 7 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11154
Item#6, FilmG405 10/18/68 km
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14163

1. DECEASED NAME (Type or print)	First JOHN	Middle H.	Last VOLZ, JR.	2a. DATE OF DEATH Month Oct. 12, 1968 Day Year M.	2b. HOUR
3. SEX male	4. RACE white	5. DATE OF BIRTH 11/29/13		6. AGE (In years last birthday) 69 24 yrs.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Newport News, Va.	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Baltimore		
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Josephs Hospital	12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) Manager-Roberson Sinclair		12b. KIND OF BUSINESS OR INDUSTRY Station	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.	13b. COUNTY Balto.	13c. CITY OR TOWN Timonium	13d. INS. & CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 133 Cinder Rd. 21093	
14. FATHER'S NAME John H. Volz, Sr.	First Middle Last	15. MOTHER'S MAIDEN NAME Augusta Buck			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? no	16b. SOCIAL SECURITY NO (If yes give war or dates of service) 213-09-8775	17. INFORMANT Ellen C. Volz (nee Casell) wife, above	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4117 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Diabetes mellitus			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5yrs		
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>January, 1968</u> , to <u>Oct. 12, 1968</u> , that (I) (we) last saw the deceased alive on <u>Oct. 6, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE 	DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 10/14/68		
22d. PHYSICIAN'S NAME (Type) Dr. Charles E. Carr	22e. ADDRESS 3900 N. Charles St.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/15/68	23c. NAME OF CEMETERY OR CREMATORIUM Baltimore Cemetery	23d. LOCATION (City or Town) Baltimore, Md.	(County) (State)	
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane	ADDRESS ADDRESS	25a. REC'D BY REGISTRAR DATE OCT 15 1968	25b. REGISTRAR'S SIGNATURE jCharles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14155

14164

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician,
 director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper
 and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. DECEASED NAME (Type or print)	First: Lester	Middle: H	Last: Wagner	20. DATE OF DEATH Month: 10 Day: 22 Year: 68	2b. HOUR 6:00 P.M.		
3. SEX Male	4. RACE White	S. DATE OF BIRTH Dec. 4, 1893	6. AGE (in years lost birthday) 74 yrs.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) New York	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore	Md.			
10 CITY OR TOWN OF DEATH Parkville	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2704 Linwood Ave	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Chief Property Officer	12b. KIND OF BUSINESS OR INDUSTRY Edgewood				
13a. USJAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.	13b. COUNTY Balto	13c. CITY OR TOWN Parkville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 2704 Linwood Ave.			
14 FATHER'S NAME Harry P. Wagner	First: Middle: Lost:	15. MOTHER'S MAIDEN NAME First: Nettie Yung	Middle: Lost:				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes	16b. SOCIAL SECURITY NO. WWI	17. INFORMANT Mrs. Elsie M. Wagner	Address 2704 Linwood Ave.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Anteriorosclerotic Cardio-vascular Disease</i> 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) Several years							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)							
MEDICAL CERTIFICATION		19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
		21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D No.	City or Town	County	State
		22a. I certify that (I) (this hospital) attended the deceased from <i>Oct. 19, 1968</i> , to <i>Oct. 19, 1968</i> , that (I) (we) last saw the deceased alive on <i>October 20, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
		22b. SIGNATURE <i>Loy M. Zimmerman M.D.</i>	ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>10/23/68</i>			
		22d. PHYSICIAN'S NAME (Type) <i>Loy M. Zimmerman M.D.</i>	22e. ADDRESS <i>3202 Harford Rd Baltimore Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE 10/25/68.	23c. NAME OF CEMETERY OR CREMATORIUM Parkwood Cemetery	23d. LOCATION (City or Town) Baltimore, Md.	(County)	(State)	
24. FUNERAL DIRECTOR Leonard J. Ruck Inc.		ADDRESS 5305 Harford Rd. #14	25a. RECD BY REGISTRAR DA OCT 23 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**
CERTIFICATE OF DEATH

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

HOSPITAL OR ATTENDING PHYSICIAN: I now request that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours from death.

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH	2b. HOUR PM
Garner A. Ward					Oct 9, 1968	12:30
3 SEX Male		4 RACE White		S. DATE OF BIRTH 3-25-1892	6. AGE (in years last birthday) 76	IF JINGER 1 YEAR MONTHS DAYS YRS.
7a BIRTHPLACE (State or foreign country) Virginia		7b CITIZEN OF WHAT COUNTRY? USA		B MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Baltimore	
10 CITY OR TOWN OF DEATH Baltimore		11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp.tol give street address) Shangri-La N.H.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Realtor - Retired		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) Md.		13c. CITY OR TOWN Balto		13d. INSIDE CITY J.M. TS? YES	13e. STREET AND NUMBER 5103 Wetheredsville Road	
14. FATHER'S NAME First Benjamin		Middle Ward	Last	15. MOTHER'S MAIDEN NAME First Navella		Middle Rippon
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? NO (Yes, no, or unknown)		16b. SOCIAL SECURITY NO 218-09-8689		17. INFORMANT Grace Sraver-6405 Lehnert Rd. 21207		Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebrovascular accident						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes
41a Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerotic CVD		DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic CVD				years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) T+1						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from 16 July, 1962 , to 9 Oct, 1968 , that (I) (we) last saw the deceased alive on 22 Aug, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Irwin H. Moss, M.D.</i>		DEGREE	ATTENDING PHYS.	XX MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 10/11/68	
22d. PHYSICIAN'S NAME (Type) Irwin H. Moss, M.D.		22e. ADDRESS 5836 Westview Mall Baltimore, Maryland 21228				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-12-68	23c. NAME OF CEMETERY OR CREMATORIAL Lorraine Cemetery		23d. LOCATION (City or Town) Baltimore, Maryland	(County) (State)
24. FUNERAL DIRECTOR		ADDRESS		25a. OCT 14 1968	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
Ellsworth Armacost-4600 Liberty Hghts. Ave						



11157

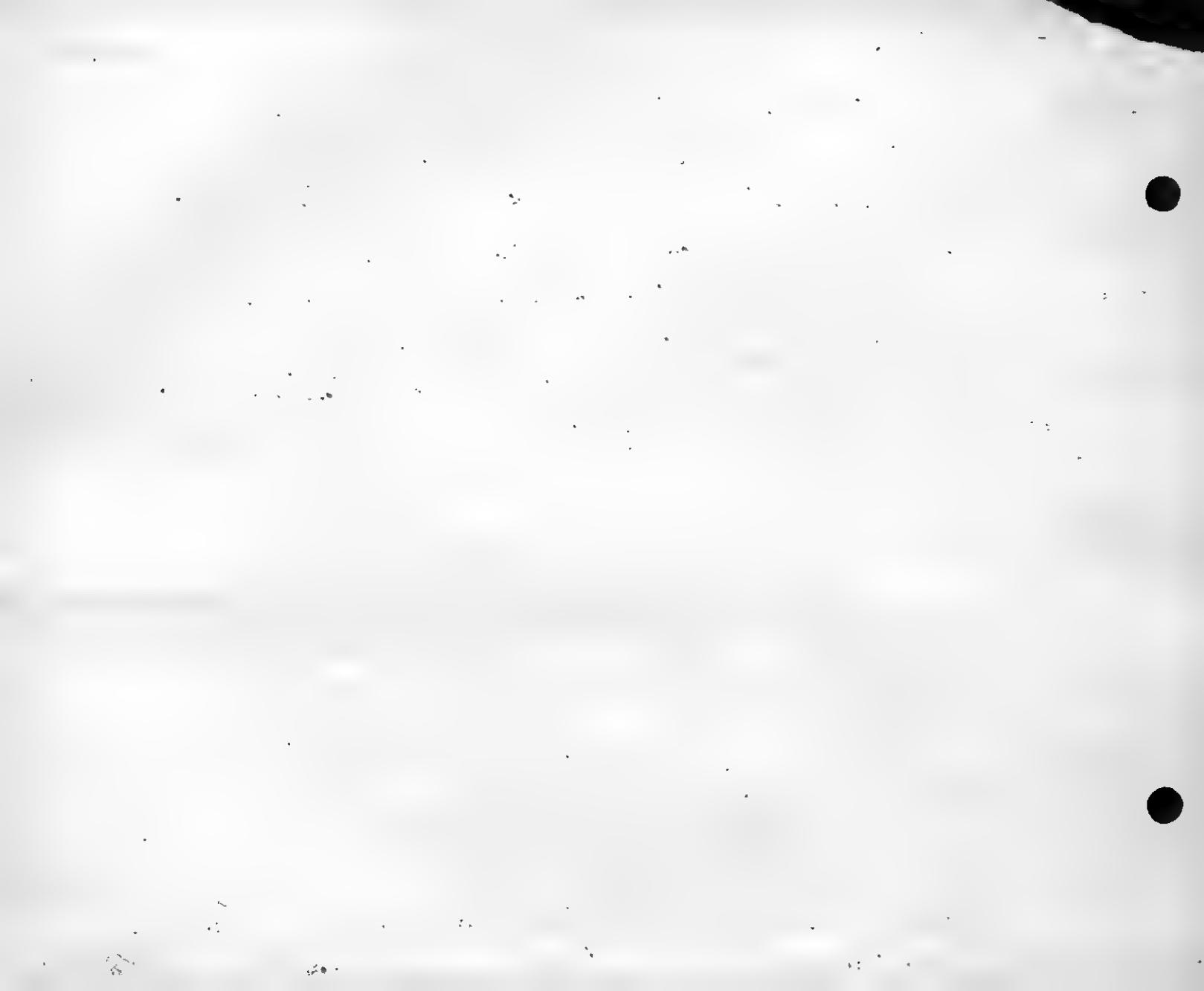
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14166

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trait permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First	Middle	Last	2d. DATE OF DEATH Month	Day	Year	2b. HOUR			
<i>Pauline Ellen Watkins</i>					<i>October 29 1968</i>						
3. SEX		4 RACE	5. DATE OF BIRTH		6 AGE (in years last birthday)			7. IF UNDER 1 YEAR MONTHS	8. IF UNDER 24 HRS. DAYS	9. IF UNDER 24 HRS. HOURS	10. MIN
<i>Female</i>		<i>White</i>	<i>July 26, 1891</i>		<i>77 yrs</i>						
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		<i>Baltimore</i>				
<i>Balto, Md U.S.A.</i>											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital giving street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
<i>Baltimore</i>		<i>3300 FAIRVIEW Rd</i>			<i>At Home</i>			<i>3300 FAIRVIEW Rd</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY L MTS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER					
<i>Md</i>		<i>BALTO</i>	<i>BALTO.</i>			<i>3300 FAIRVIEW Rd</i>					
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last		
		<i>Albert</i>		<i>Abe</i>	<i>UNKNOWN</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
		<i>-</i>		<i>Mildred Kelch - Route 4 Box 278 Elkwater, Md 21037</i>				<i>5 yrs</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Malignancy - Breast - metastasis</i> DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>174 X</i>											
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
		<i>1/10/68</i>		<i>-</i>		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <input type="checkbox"/> P.M. Month Day Year <input type="checkbox"/> While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>19</i>							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <i>1965</i> , to <i>10/29 1968</i> , that (I) (we) last saw the deceased alive on <i>10/20 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>W. S. Williams, M.D.</i>		22c. DEGREE <i>M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		DATE SIGNED <i>10/30/68</i>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City or Town)		(County)		(State)	
<i>BURIAL</i>		<i>11-2-68</i>		<i>Loudon Park Cemetery</i>		<i>Baltimore, Md</i>					
24. FUNERAL DIRECTOR		ADDRESS		25a. REGD. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
		<i>Elsworth Armagost - 4600 Liberty Heights Ave.</i>		<i>NOV 1 1968</i>		<i>Charles Judge</i>					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

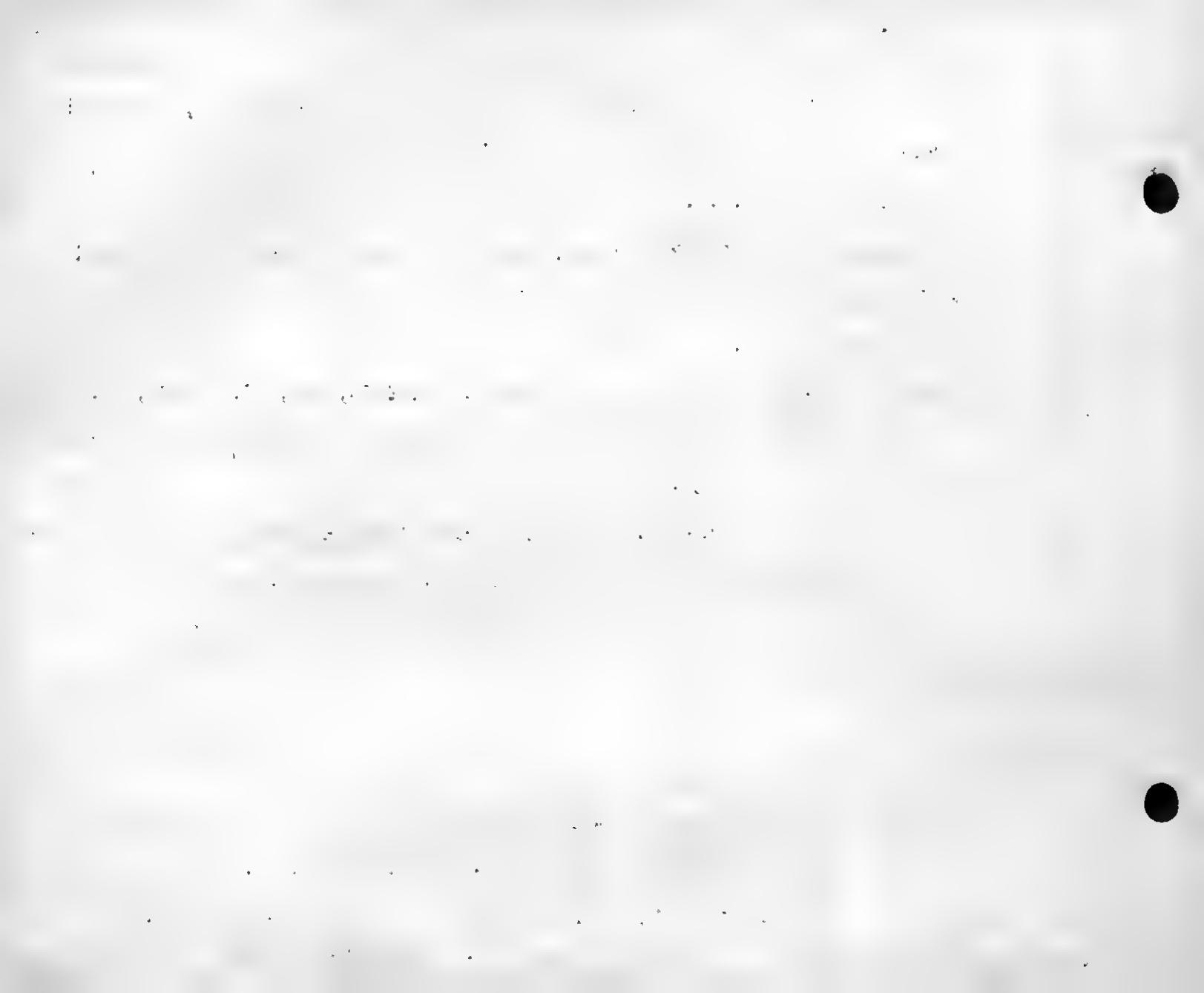
CERTIFICATE OF DEATH

14167

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers from page 3 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First CHARLES	Middle WALLACE	Last WEBB	2a. DATE OF DEATH Month OCTOBER	Day 24 , 19 68	Year 1968	2b. HOUR 10:20 P.M.		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 10/11/18		6. AGE (In years last birthday) 50 YRS				
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE				
10. CITY OR TOWN OF DEATH FORT HOWARD		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VETERANS ADMIN. HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) MACHINE ADJUSTER			12b. KIND OF BUSINESS OR INDSTRY STATIONERY			
13a. U.S.A. RESIDENCE (Where deceased lived, if institution admission) STATE MARYLAND		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4118 ARDLEY AVENUE				
14. FATHER'S NAME GEORGE		First D.	Middle WEBB	15. MOTHER'S MAIDEN NAME ELEANOR		Middle --			Last BRADY	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input checked="" type="checkbox"/> (If yes give war or dates of service) WWII		16b. SOCIAL SECURITY NO. 212 07 80 74		17. INFORMANT CLINICAL RECORDS, VAH, FT. HOWARD, MD.		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, BILATERAL, UNDETERMINED ORGANISM										DAYS
4 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost.										UNKNOWN
(b) ENCEPHALOMALACIA, RIGHT										UNKNOWN
DUE TO, OR AS A CONSEQUENCE OF (c) CEREBRAL ARTERIOSCLEROSIS, BASILAR ARTERY OCCLUSION										UNKNOWN
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)										
LAENNEC'S CIRRHOSIS. DIABETES MELLITUS. ARTERIOSCLEROTIC HEART DISEASE										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			YES
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from OCT 23 , 19 68 , to OCT 24 , 19 68 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on OCT 24 , 19 68 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> view the body after death.										
22b. SIGNATURE <i>Neilson Neilson</i>		22c. DEGREE <input type="checkbox"/> ATTENDING PHYS.		<input type="checkbox"/> MED. DIRECTOR		<input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22d. DATE SIGNED 10/25/68		
22d. PHYSICIAN'S NAME (Type) NEILSON NEILSON, M. D.		22e. ADDRESS VAH, FT. HOWARD, MD.								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 10/28/68		23c. NAME OF CEMETERY OR CREMATORIAL BALTIMORE NATIONAL		23d. LOCATION (City or Town) BALTIMORE, MARYLAND		(County) MARYLAND		(State)
24. FUNERAL DIRECTOR <i>Robert C. Altenburg</i>		ADDRESS ROBERT C. ALTBURG FUNERAL HOME		25a. RECEIVED BY REGISTRAR 10/25/68		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				
VR A15 14 30M REV. 1/68										



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

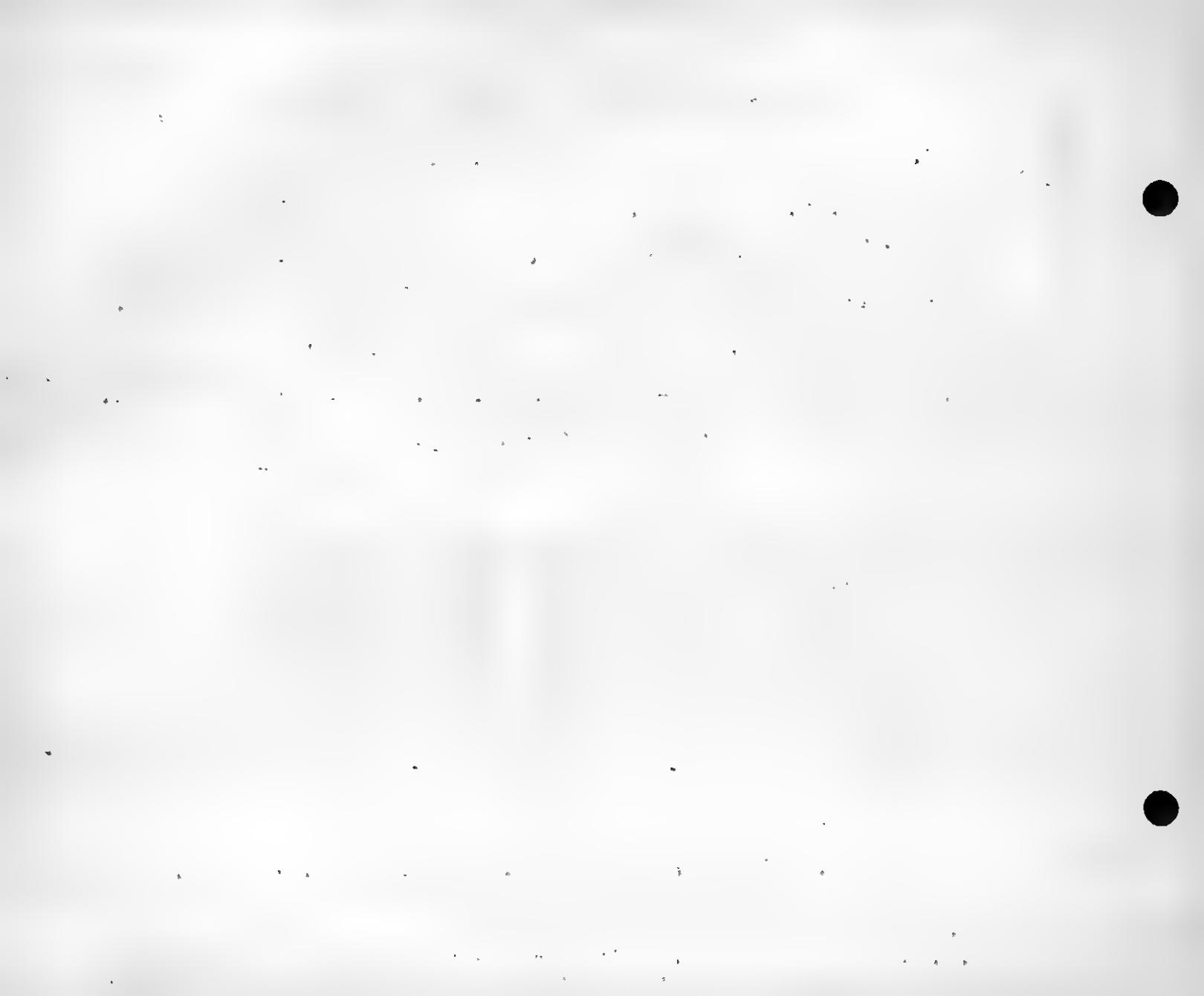
14159

14168

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. In any event, within 24 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1 DECEASED NAME (Type or print)		First Marvin	Middle Elco	Lost Webb	2a DATE OF DEATH Month October	Day 24	Year 1968	2b. HOUR 3 P.M.
3 SEX M		4. RACE W		5. DATE OF BIRTH Nov. 7, 1891		6. AGE (In years lost birthday) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (State or foreign country) Madison Cty. Ga.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore		
10. CITY OR TOWN OF DEATH Lutherville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 404 Towson Ave.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Farmer		12b KIND OF BUSINESS OR INDUSTRY Farming		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Georgia		13c CITY OR TOWN Bowman		13d. INSIDE CTY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER North Broad St.		
4. FATHER'S NAME First Robert		Middle F.	Lost Webb	15. MOTHER'S MAIDEN NAME First Unknown.		Middle	Lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes		16b. SOCIAL SECURITY NO. WWI 257-28-0904		17. INFORMANT Robert M. Webb, 404 Towson Ave.		Address Lutherville, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Arteriosclerotic cardio vascular disease						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Parkinsonism		DUE TO, OR AS A CONSEQUENCE OF (b) Diabetes mellitus						
		DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Parkinsonism								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING □ CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from 11-13, 1963 , to 10-24, 1968 , that (I) (we) last saw the deceased alive on 10-22, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Alfred G. Ossman Jr.		DEGREE Jr.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 1101 St. Paul St.		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS						
Dr. Alfred G. Ossman, Jr.		1101 St. Paul St.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Rem. Burial		23b. DATE 10/26/68		23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest		23d. LOCATION (City or Town) Bowman		(County) Ga.
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Rd. Balto. 12. Md.		25a. REC'D BY REGISTRAR OCT 25 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

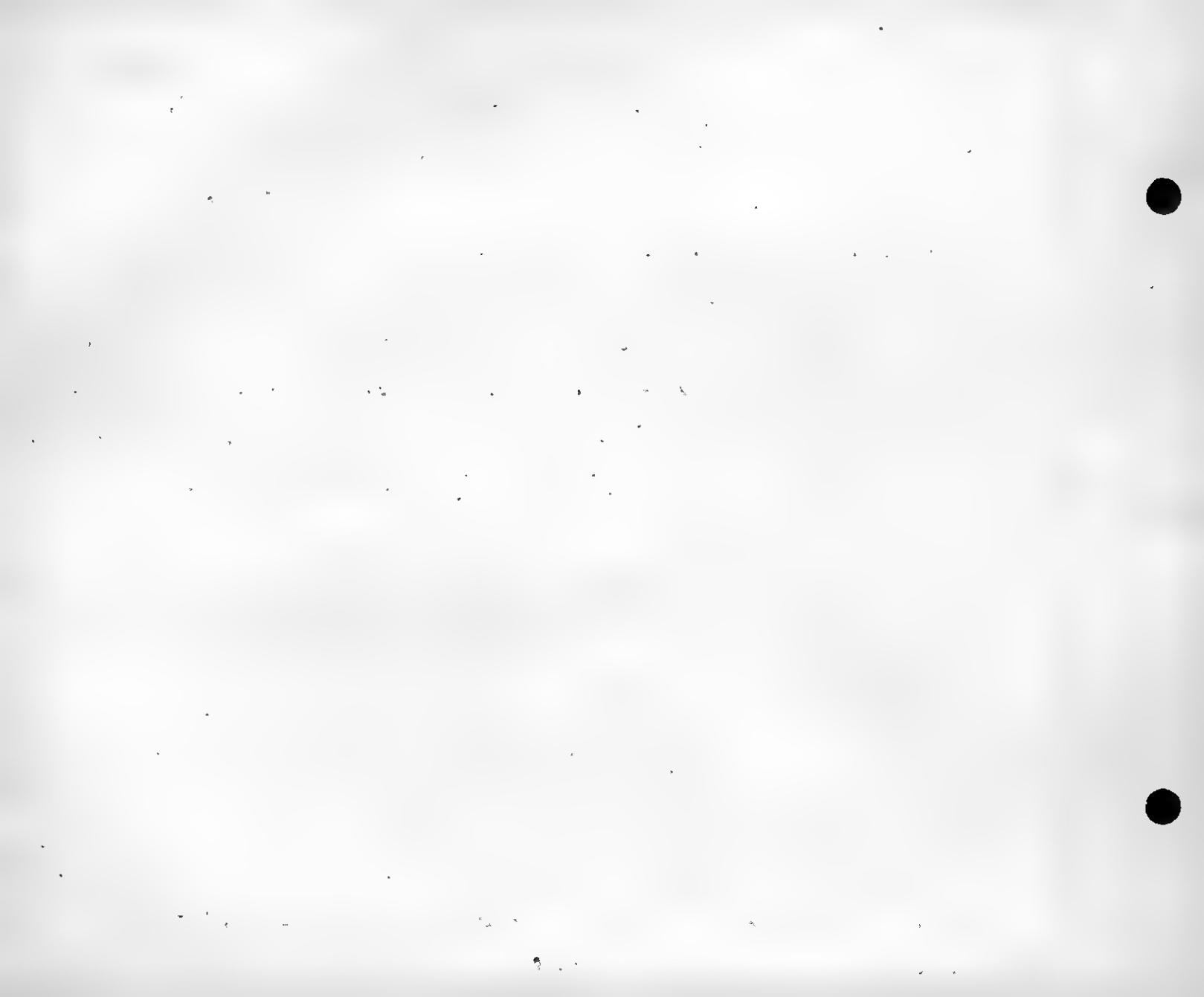


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

ATTENDANT PHYSICIAN The law requires that the death certificate be executed within 24 hours after death.

0 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR 4:30 P.M.
George L. Webster						October 7, 1968	
3. SEX Male		4. RACE White		5. DATE OF BIRTH May 19, 1897		6. AGE (In years last birthday) 71 YRS	
7a. BIRTHPLACE (State or foreign country) Scotland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore	
10. CITY OR TOWN OF DEATH Lutherville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 14 W. Seminary Ave.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Teacher		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Lutherville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 14 W. Seminary Ave.
14. FATHER'S NAME First Alexander		Middle Webster	Last	15. MOTHER'S MAIDEN NAME First Elizabeth		Middle	Last McIntyre
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes		16b. SOCIAL SECURITY NO. WWI 219-01-6884		17. INFORMANT Mrs. Naomi Webster		Address 14 W. Seminary Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Primary Carcinoma left lung DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause Arterio - Sclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (b) 6 yrs. (c) 8 months							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from Oct. 2, 1968, to Oct. 7, 1968, that (I) (we) last saw the deceased alive on Oct. 2, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Earl L. Chambers M.D.		DEGREE	ATTENDING PHYS. Dr. Earl L. Chambers	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 10/18/68	
22d. PHYSICIAN'S NAME (Type) Earl L. Chambers		22e. ADDRESS #160-W. Cold Spring Rd., Baltimore, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/10/68	23c. NAME OF CEMETERY OR CREMATORIAL Moreland Memorial Cem.		23d. LOCATION (City or Town) Baltimore, Maryland		(County) (State)
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson 1050 York Rd. 21204		ADDRESS		25a. REC'D BY REGISTRAR DATE OCT 9 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

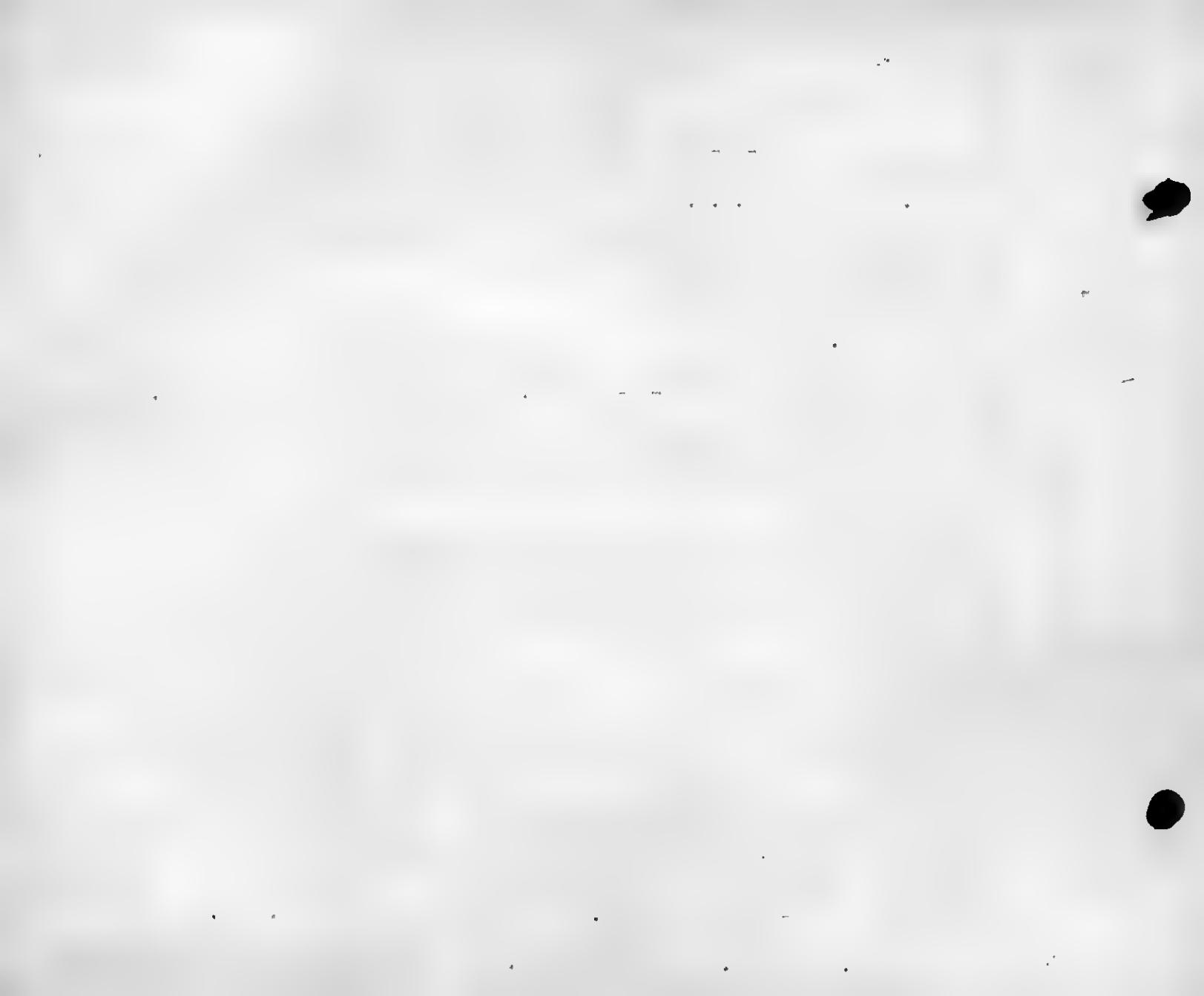


FOR STATE
HEALTH DEPT.

6
11161 Item 11 F
14170

Health prior to burial, cremation, or removal, and in any event within 72 hours after death
TO DEPUTY: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH												14170
1. DECEASED NAME (Type or Print)			First	Middle	Last	(WEEKS)	2a DATE KNOWN OF ESTI- DEATH	Month	Day	Year	2b HOUR P.M.	
RUTH			BAKER	WEEKS	10/25/68	19	2:00					
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (in years last birthday)	7 IF UNDER 24 HRS.	MONTHS	DAYS	HOURS	MIN	2c DATE PRONOUNCED DEAD	2d HOUR P.M.		
female	white	1-20-12	56 yrs.						October 23, 1968	2:00		
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9 COUNTY OF DEATH				
Md.		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				Baltimore				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)			12a. L.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore County			Giant Super Market Loch Raven & Taylor Avenues			Housewife						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER			
Maryland			Baltimore			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			6111 Moyer Avenue			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last	
John F. Ellis						Carrie Straysinger						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
No			216-11-3837			C. Kenneth Weeks, 6111 Moyer Ave.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY												
IMMEDIATE CAUSE (a) Arteriosclerotic and Hypertensive Cardiovascular Disease												
1120 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b), lost.												
(b) DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?			
									YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town	County	State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>Kenneth Spitz</i>			MD			CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type)			Werner U. Spitz, M.D.			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED 10/26/68			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial			23b. DATE 10-29-68			23c. NAME OF CEMETERY OR CREMATORIAL Gdns. of Faith			23d. LOCATION (City or Town) Balto., Md.			
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
Leonard J. Ruck, Inc., 5305 Harford Rd.						DATE OCT 28 1968						
VR A15ME (5) 10M REV 1/68												



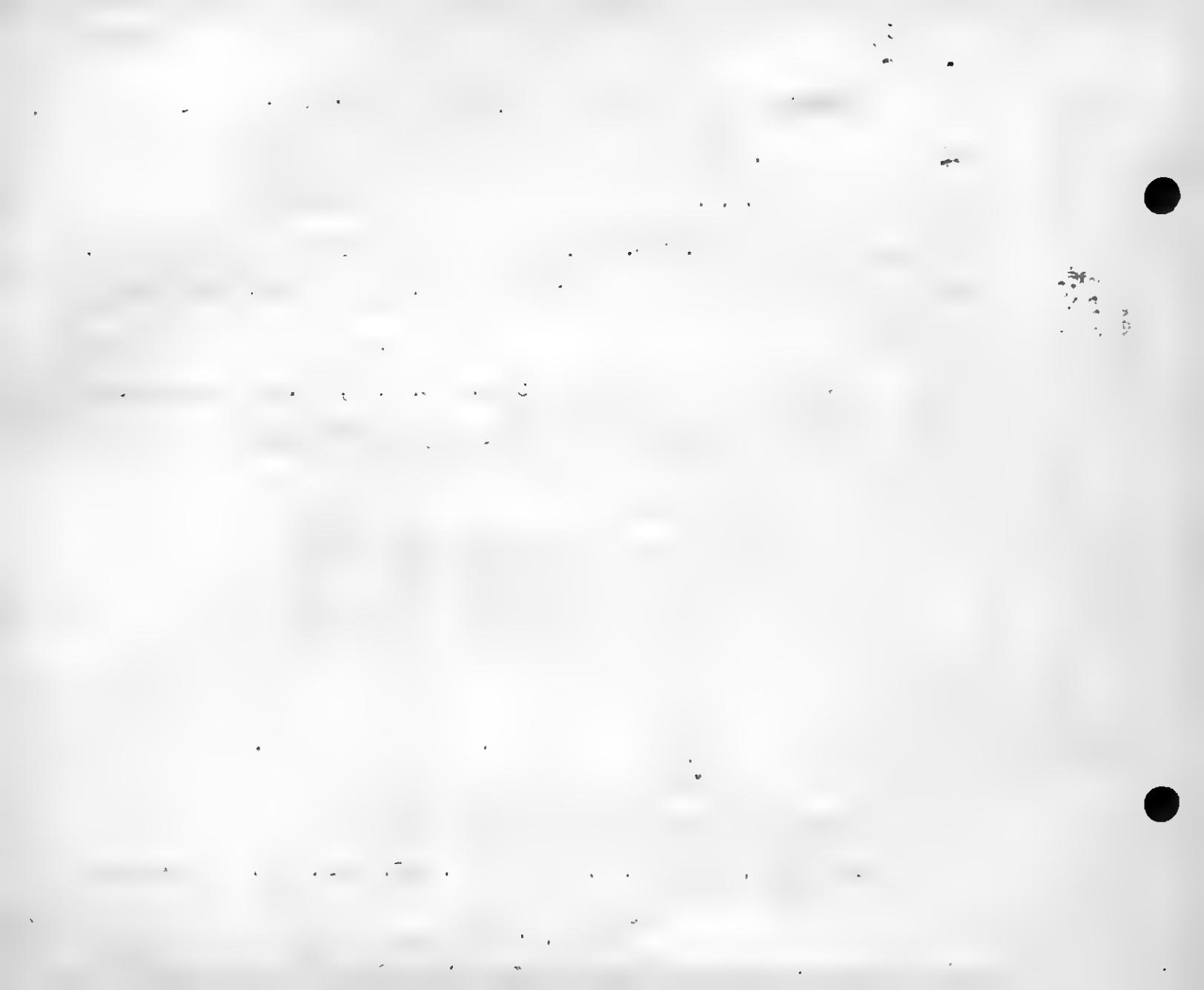
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

11162

14171

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First AUGUST	Middle JOHN	Lost WEIS	20. DATE OF DEATH OCTOBER	Month 17	2b. HOUR 4:05 p.m.		
3. SEX MALE		4. RACE WHITE		S. DATE OF BIRTH 12 11 08	6. AGE (in years lost birthday) 59 yrs.		IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	IF UNDER 24 MINS. HOURS 0
7a. BIRTH-PLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE				
10. CITY OR TOWN OF DEATH FORT HOWARD		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VET. ADM. HOSPITAL		12a. USJAL OCCUPATION (Kind of work done during most of working life, even if retired) ATTENDANT		12b. KIND OF BUSINESS OR INDUSTRY CITY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) MARYLAND		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 405 MONTFORD AVENUE				
14. FATHER'S NAME First ADAM WEIS		Middle 	Lost 	15. MOTHER'S MAIDEN NAME First MARY		Middle 	Lost STERN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES		16b. SOCIAL SECURITY NO. 215 03 9205		17. INFORMANT CLIN. REC., VAH, FORT HOWARD, MARYLAND		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA, RECTO-SIGMOID, FAR ADVANCED						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 MONTHS			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner.)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No		City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from Oct. 8, 1968 , to Oct. 17, 1968 , that (I) (we) last saw the deceased alive on October 17, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Alfonso A. Lopez</i>		DEGREE M.D.	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED 10 17 68			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS VET. ADM. HOSP., FT. HOWARD, MARYLAND							
23a. BURIAL, CREMATION, BUREAU (If applicable)		23b. DATE 10-21-68		23c. NAME OF CEMETERY OR CREMATORIAL BALTIMORE NATIONAL		23d. LOCATION (City or Town) BALTIMORE		(County) MARYLAND	
24. FUNERAL DIRECTOR <i>Harley Miller</i>				ADDRESSEES Harley A. Miller 2334 Jefferson St.		RECD BY REGISTRAR OCT 22 1968	25b. REGISTRAR'S SIGNATURE <i>Charles J. George</i>		
VR A 144 30M REV 12/64									



**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 2 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
15ME75
REV A

VR A15ME
10M REV N

1 DECEASED-NAME (Type or Print)	First WILLIAM	Middle Thomas	Last Welch	2a. DATE KNOWN OF EST. DEATH MATED	Month Oct.	Day 13,	Year 1968	2b HOUR 00:00
3 SEX Male	4 RACE White	5. DATE OF BIRTH Sept 21 1902	6. AGE (In years last birthday) 66 YRS	7. IF UNDER 1 YEAR MONTHS 5601	8. IF UNDER 24 HRS DAYS Union Hospital	9. COUNTY OF DEATH Baltimore	10. DATE PRONOUNCED DEAD Month Oct.	11. 2d HOUR Day 13, 1968
7a. BIRTHPLACE (State or foreign country) Md	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore	10. CITY OR TOWN OF DEATH UNK? Woodlawn	11. NAME OF HOSPITAL OR INSTITUTION (If not hospital give street address) Winchester Mill Rd	12a. SUEL OCCUPATION (Kind of work done during most of working life, even if retired) Weaver	12b. KIND OF BUSINESS OR INDUSTRY Textik	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) Md ??	13b. COUNTY ??	13c. CITY OR TOWN ?? Belto	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER UNK? 1501 Cox St				
14. FATHER'S NAME Thomas William Welch	First	Middle	Last	15. MOTHER'S MAIDEN NAME Caroline Myers	First	Middle	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) No	16b. SOCIAL SECURITY NO (If yes give war or dates of service) 214 03 5320	17. INFORMANT Mildred Welch	18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Epilepsy DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)	ADDRESS 1501 Cox St Baltimore	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 19a. DATE OF OPERATION								
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (At home, form street factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State			
22o. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Edward F. Wilson, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>	22b. DATE SIGNED October 14, 1968				
EXAMINER'S NAME (Type)	M.D.	ADDRESS	ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	ADDRESS (Street, city, town or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Oct 17 1968	23c. NAME OF CEMETERY OR CREMATORIUM St. Mary's Cemetery (Hampden)	23d. LOCATION (City or Town) Roland Ave Belto Md	(County) Baltimore	(State) Md			
24. FUNERAL DIRECTOR Burgess Funeral Home Belto Md	ADDRESS	25a. REC'D BY REG STAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge					
DATE OCT 21 1968								



18164

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14173

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the deceased has been signed by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH	2b. HOUR		
Lyell		E		Wellmeyer Sr	Month 10 Day 9 Year 68	M		
3. SEX		4. RACE		S. DATE OF BIRTH	6. AGE (In years last birthday)			
Male		White		April 10, 1901	67	YRS	IF UNDER 1 YEAR	IF UNDER 24 HRS.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH			
Iowa		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Baltimore			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore		Gr. Balt. Med. Center		Foreman		Beth. Steel		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER			
Maryland		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	3624 Delverne Rd			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last
		George		Wellmeyer	Amanda			Sage
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address		
Yes		XX 213-09-3893		Mrs Naomi L Wellmeyer		Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>systolic pneumonia</u> APPROXIMATE INTERVAL DUE TO, OR AS A CONSEQUENCE OF <u>4 days</u> Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) <u>pathologic fracture left femur</u> 4 mos DUE TO, OR AS A CONSEQUENCE OF lost (c) <u>cancerous of the prostate.</u> 1 year								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>nil</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
6/10/68		pathologic fracture left femur			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	no		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CASE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>6-10</u>, 19<u>68</u>, to <u>10-8</u>, 19<u>68</u>, that (I) (we) last saw the deceased alive on <u>10-8</u>, 19<u>68</u>, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		John J. Fahey MD DEGREE			ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (Type)		John J. Fahey, M. D.			22e. ADDRESS	<u>1117 St. Paul Street, Baltimore 21202</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIALy			23d. LOCATION (City or Town)	(County)	(State)
Burial		10/12/68	Parkwood			Baltimore, Maryland		
24. FUNERAL DIRECTOR		ADDRESS			25a. REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE		
		Leonard J Ruck Inc. Baltimore Maryland			OCT 11 1968	Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16165

CERTIFICATE OF DEATH

14174

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR 5:15 M	
JOSE PHIL LEONARD WELSH				10	30	1968		
3. SEX M	4. RACE W	5. DATE OF BIRTH 2-17-91			6. AGE (In years lost birthday) 77 yrs		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore		
10. CITY OR TOWN OF DEATH Baltimore City		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE S. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 8141-157th ave. (Md)		
14. FATHER'S NAME CHARLES E WELSH		15. MOTHER'S MAIDEN NAME LOTTA			16. Address Bump			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO 577-03-1032		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Secondary of arteriosclerotic heart disease</u>								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 71.1								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>7-19, 1966</u> , to <u>10/30, 1968</u> , that (I) (we) last saw the deceased alive on <u>10-30-68</u> 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Dr. Alberto A. Felipe MD</u>								
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS SPRING-GROVE-STATE HOSPITAL		22c. DATE SIGNED 10/30/68				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov 3, 1968		23c. NAME OF CEMETERY OR CREMATORIUM FORT LINCOLN CEM		23d. LOCATION (City or Town) COLMAR MANOR, MARYLAND (County) (State)		
24. FUNERAL DIRECTOR B.P. W.W. CHAMBERS		ADDRESS RIVERDALE, MD.		25a. REC'D BY REGISTRAR DATE NOV 4 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14175

14168

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, sign and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First <i>Robert</i>	Middle <i>White</i>	Last <i>White</i>	2a DATE OF DEATH Month <i>Tues. Oct.</i>	2b HOUR Year <i>8-1968 6AM</i>
3. SEX <i>Male</i>		4 RACE <i>White</i>	5 DATE OF BIRTH <i>July 29, 1901</i>		6 AGE (in years last birthday) <i>67</i>	7b HOURS MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (State, or foreign country) <i>Baltimore USA</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i>	
10 CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Hickory Manor</i> <i>3743 Edmonson Ave</i>		12a USUAL OCCUPATION (Kind of work done During most of working life, even if retired) <i>Peddler - Dances on Street</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Sold Laces and</i>
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <i>No.</i>		13c CITY OR TOWN <i>Baltimore</i>	13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER <i>915 Montpelier St. 21218</i>	
14. FATHER'S NAME <i>Robert</i>		Middle <i>White</i>	Last <i>White</i>	15. MOTHER'S MAIDEN NAME First <i>Jennie May</i>	Middle <i>Priscoll</i>	Last <i>anderson</i>
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b SOCIAL SECURITY NO. <i>944-35-0000</i>		16c INFORMANT <i>Jennie May Brown</i>	Address <i>Montpelier St. 21218</i>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>and</i>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Carcinoma stomach</i>		DUE TO, OR AS A CONSEQUENCE OF (b) <i></i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>last.</i>		DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i></i>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY (OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. <i>1334 Sulphur Spring Rd - 21227</i>	City or Town <i>Baltimore</i>	County <i>21227</i>	State <i>Md.</i>
22a. I certify that (I) (this hospital) attended the deceased from <i>1 Apr. 1968</i> , to <i>8 Oct. 1968</i> , that (I) (we) last saw the deceased alive on <i>9 Oct. 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>William Goodman</i>		DEGREE <i>MD</i>	ATTENDING PHYS. <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>8 Oct 68</i>		
22d. PHYSICIAN'S NAME (Type) <i>William Goodman, MD</i>		22e. ADDRESS <i>1334 Sulphur Spring Rd - 21227</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Oct. 13-1968</i>	23c. NAME OF CEMETERY OR CEMETORY <i>Holy Cross Cemetery</i>	23d. LOCATION (City or Town) <i>Baltimore</i>	(County) <i>21227</i>	(State) <i>Md.</i>
24. FUNERAL DIRECTOR <i>Curtis E. Evans</i>		ADDRESS <i>14005 Charles</i>	25a. REC'D BY REGISTRAR <i>Baltimore 11-1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

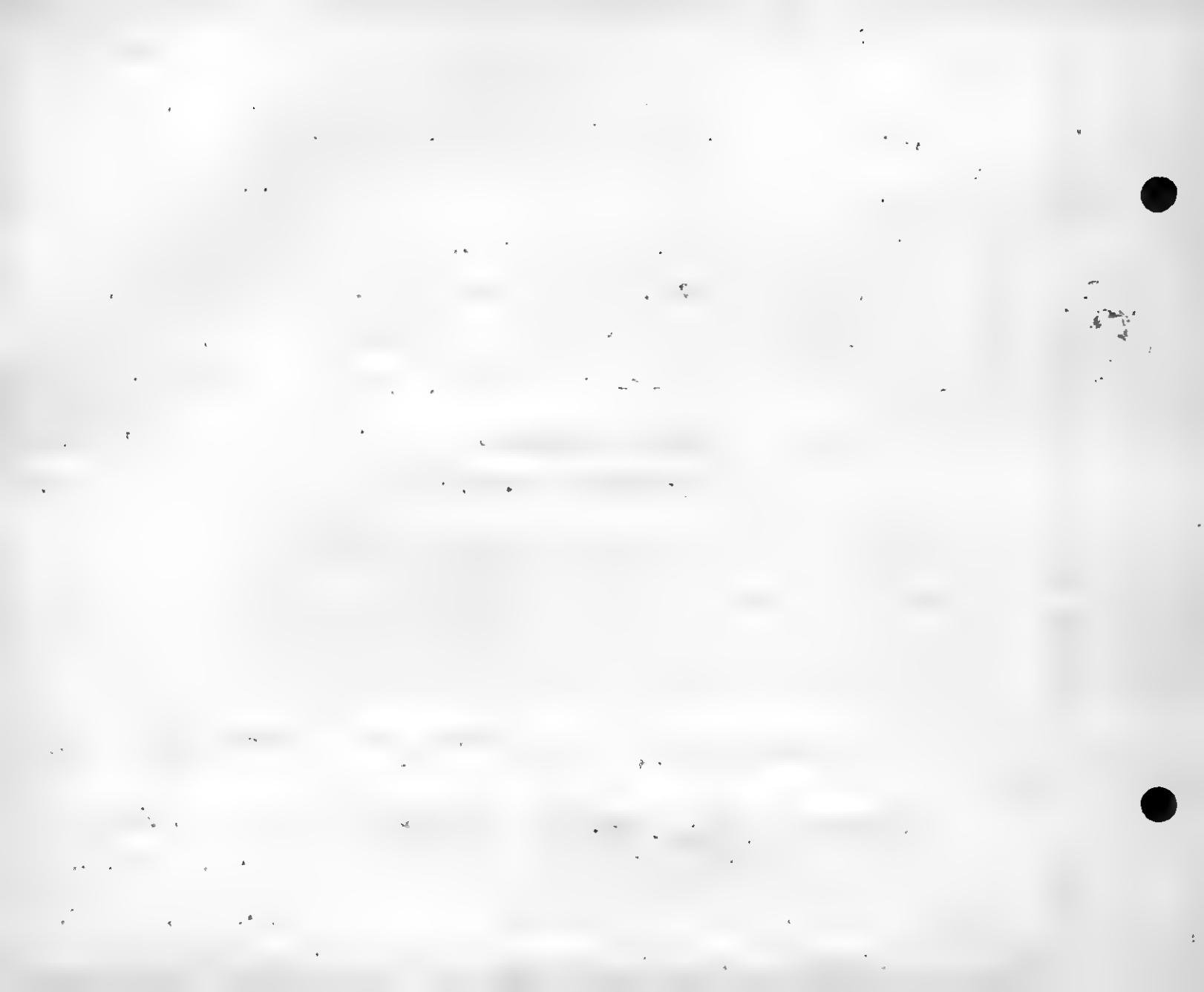
12167

14176

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 from this certificate, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Luella	Middle M.	Last Whitekettle	2a. DATE OF DEATH Month Oct.	Day 20, 1968	Year 1968	2b. HOUR M
3. SEX female	4 RACE white	5. DATE OF BIRTH January 11, 1901			6 AGE (In years last birthday) 87	IF UNDER MONTHS YRS.	YEAR DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Penna.	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore				
10. CITY OR TOWN OF DEATH Thornleigh		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1609 Templeton Rd.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) homemaker		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Balto.	13c. CITY OR TOWN Thornleigh	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER 1609 Templeton Rd.	12b. KIND OF BUSINESS OR INDUSTRY		
14. FATHER'S NAME First Charles	Middle A.	Last Smith	15. MOTHER'S MAIDEN NAME First Margaret	Middle E.	Last Davis		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. 161-03-5782B	17 INFORMANT Howard C. Whitekettle	Address 1609 Templeton Rd. #4				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMATOSIS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) UTERINE CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 YEAR	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 124X							
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year PM 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (Donald Sommerville) attended the deceased from 10/18 , 19 68 , to 10/26 , 19 68 , that (I) (Donald Sommerville) last saw the deceased alive on 10/25 , 19 68 , and that in (my) (Donald Sommerville) opinion death occurred on the date and hour and from the causes stated above, (I) (Donald Sommerville) did not view the body after death.							
22b. SIGNATURE Donald L. Sommerville, MD		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 10/28/68		
22d. PHYSICIAN'S NAME (Type) Dr. Donald Sommerville		22e. ADDRESS 25 W. Penna. Ave. Towson, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/29/68	23c. NAME OF CEMETERY OR CREMATORIAL Druid Ridge			23d. LOCATION (City or Town) Pikesville,	(County) Md.	(State)
24. FUNERAL DIRECTOR ADDRESS Mitchell-Wiedefeld Home 6500 York Road Balto., Md. 21212					25a. REC'D BY REGISTRAR NOV 1 1968	25b. REGISTRAR'S SIGNATURE Charles J. Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14177

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First G. Raymond Wilhelm	Middle 	Lost 	2a. DATE OF DEATH Month <i>Oct</i> 7 Day <i>1968</i> Year <i>1968</i>	2b. HOUR <i>5:30 PM</i>	
3. SEX Male	4. RACE White	5. DATE OF BIRTH Nov. 24, 1900		6. AGE (In years last birthday) <i>87</i>	IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS DAYS <i>0</i>	2b HOUR HOURS <i>0</i>
7a. BIRTHPLACE (State or foreign country) Balto. Co. Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	9. COUNTY OF DEATH Balto.				
10. CITY OR TOWN OF DEATH Upperco	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) RD	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Operator		12b. KIND OF BUSINESS OR INDUSTRY Balto. G&E			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Balto.	13c. CITY OR TOWN Parkton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER RD			
14. FATHER'S NAME First George W. Wilhelm	Middle 	Lost 	15. MOTHER'S MAIDEN NAME First Ida V. Hale	Middle 	Last 		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No or unknown No	16b. SOCIAL SECURITY NO. 212-05-4146	17. INFORMANT Charlotte Wilhelm Parkton, Md. (Wife)	Address Charlotte <i>Brennan</i> Quinton <i>Midway</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>midway</i>	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Charlotte Brennan</i> <i>Quinton</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). (b) <i>Underlying cause</i> stating the underlying cause last. (c) <i>Underlying cause</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION <i>4/21/68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 7, 1968</i> , to <i>Oct 7, 1968</i> , that (I) (we) last saw the deceased alive on <i>Oct 7, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Joseph E. Bush MD</i>		DEGREE <i>MD</i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>10-7-68</i>	
22d. PHYSICIAN'S NAME (Type) <i>Joseph E. Bush MD</i>		22e. ADDRESS <i>Hampstead MD</i>					
23a. BURIAL, CREMATION, REINTERMENT <i>Burial</i>		23b. DATE <i>Oct. 10, 1968</i>	23c. NAME OF CEMETERY OR CREMATORY Forest Cemetery	23d. LOCATION (City or Town) Upperco, Balto. Co. Md.		(County) Hampstead	(State) Md.
24. FUNERAL DIRECTOR Tipton - Eline Funeral Home Hampstead, Md.		ADDRESS		25a. REC'D BY REGISTRAR OCT 10 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



11163

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14178

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)	First ALBERT	Middle -	Last WILLIAMS	2a. DATE OF DEATH Month: OCTOBER Day: 25 , Year: 1968	2b. HOUR 5:40 P.M.
3. SEX MALE	4. RACE NEGROID	S. DATE OF BIRTH 7 3 20	6. AGE (In years last birthday) 48 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN. 0	
7a. BIRTHPLACE (State or foreign country) N.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE	Md.	
10. CITY OR TOWN OF DEATH FORT HOWARD	11. NAME OF HOSPITAL OR INSTITUTION (If not in box give street address) HOSPITAL VETERANS ADMINISTRATION	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) TRUCK DRIVER	12b. KIND OF BUSINESS OR INDSTRY CONSTRUCTION		
13a. JS/JAL RESIDENCE (Where deceased lived, if institution. Residence before admission) MARYLAND	13b. CITY OR TOWN BALTIMORE	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1028 N BROADWAY		
14. FATHER'S NAME First WILLIE	Middle WILLIAMS	15. MOTHER'S MAIDEN NAME First DAVIS	Middle BROWN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) YES	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 244 18 5935	17. INFORMANT CLINICAL RECORDS, VA HOSP., FT HOWARD, MD	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) OAT CELL CARCINOMA OF RT LUNG WITH METASTASIS 16 d. 1 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1621					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory) (OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9/9/68 , 19 19 , to 10/25/68 , 19 19 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10/25/68 , 19 19 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (not) view the body after death.					
22b. SIGNATURE <i>Sung Ill Shin M.D.</i>	DEGREE ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 10 26 68	
22d. PHYSICIAN'S NAME (Type) SUNG ILL SHIN, M.D.	22e. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE Nov 7/68	23c. NAME OF CEMETERY OR CREMATORIAL BALTIMORE NATIONAL	23d. LOCATION (City or Town) BALTIMORE, MARYLAND	(County) MARYLAND	(State) MARYLAND
24. FUNERAL DIRECTOR ELLIOTT FUNERAL HOME, 1129 N CAROLIN ST, BALTO,	ADDRESS MD.	25a. FILED BY REGISTRY NOV 8 1968	25b. FILER'S SIGNATURE <i>James J. ...</i>		

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

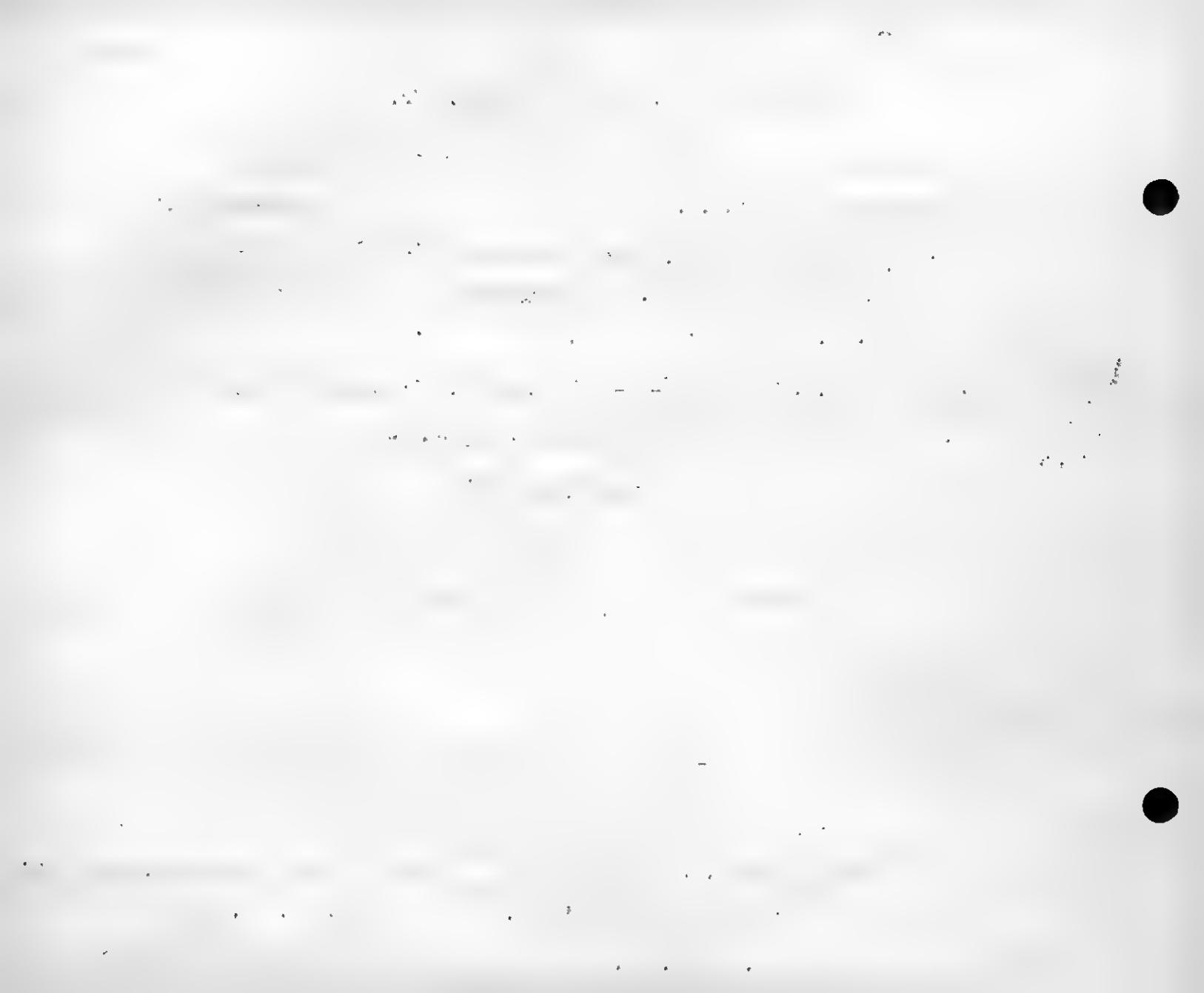
CERTIFICATE OF DEATH

14179

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. If either, notify medical examiner.)

1. DECEASED NAME (Type or print)		First John	Middle B.	Last Williams Jr.	2a. DATE OF DEATH Month 10	Doy 7	Year 68	2b HOUR 2:45PM		
3. SEX male	4. RACE white	5. DATE OF BIRTH 3-5-17			6. AGE (in years last birthday) 51 yrs.		IF UNDER 1 YEAR MONTHS 0	IF JUNR 24 HRS. HOURS 0	MIN 0	
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Co.					
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Trucking Self-employed			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Balte.	13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 3301 Acton Road			
14. FATHER'S NAME First John B.	Middle Williams	Last Sr.	15. MOTHER'S MAIDEN NAME First Emma			Middle Rogers	lost			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	16b. SOCIAL SECURITY NO. W.W. 2	17. INFORMANT Mary E. Williams			Address same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute Myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any which gave rise to immediate cause (a). stating the underlying cause lost. (b) Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4109										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY (OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10-7-68 , to 10-7-68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10-7-68 19, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did not) view the body after death.										
22b. SIGNATURE <i>Samuel Lee, M.D.</i>		DEGREE ATTENDING PHYS.	<input type="checkbox"/>	MED DIRECTOR	<input type="checkbox"/>	STAFF PHYS.	<input checked="" type="checkbox"/>	22c. DATE SIGNED 10-7-68		
22d. PHYSICIAN'S NAME (Type) Samuel Lee, M.D.		22e. ADDRESS 7620 York Road, Baltimore, Md. 21201								
23a. BURIAL, CREMATION, BONE BANK (Specify) Burial		23b. DATE 10/10/68		23c. NAME OF CEMETERY OR CREMATORIAL Parkwood Cem.		23d. LOCATION (City or Town) Balte. Md.		(County)	(State)	
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balte. Md.		ADDRESS			25a. REC'D BY REGISTRAR OCT 8 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



14171

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

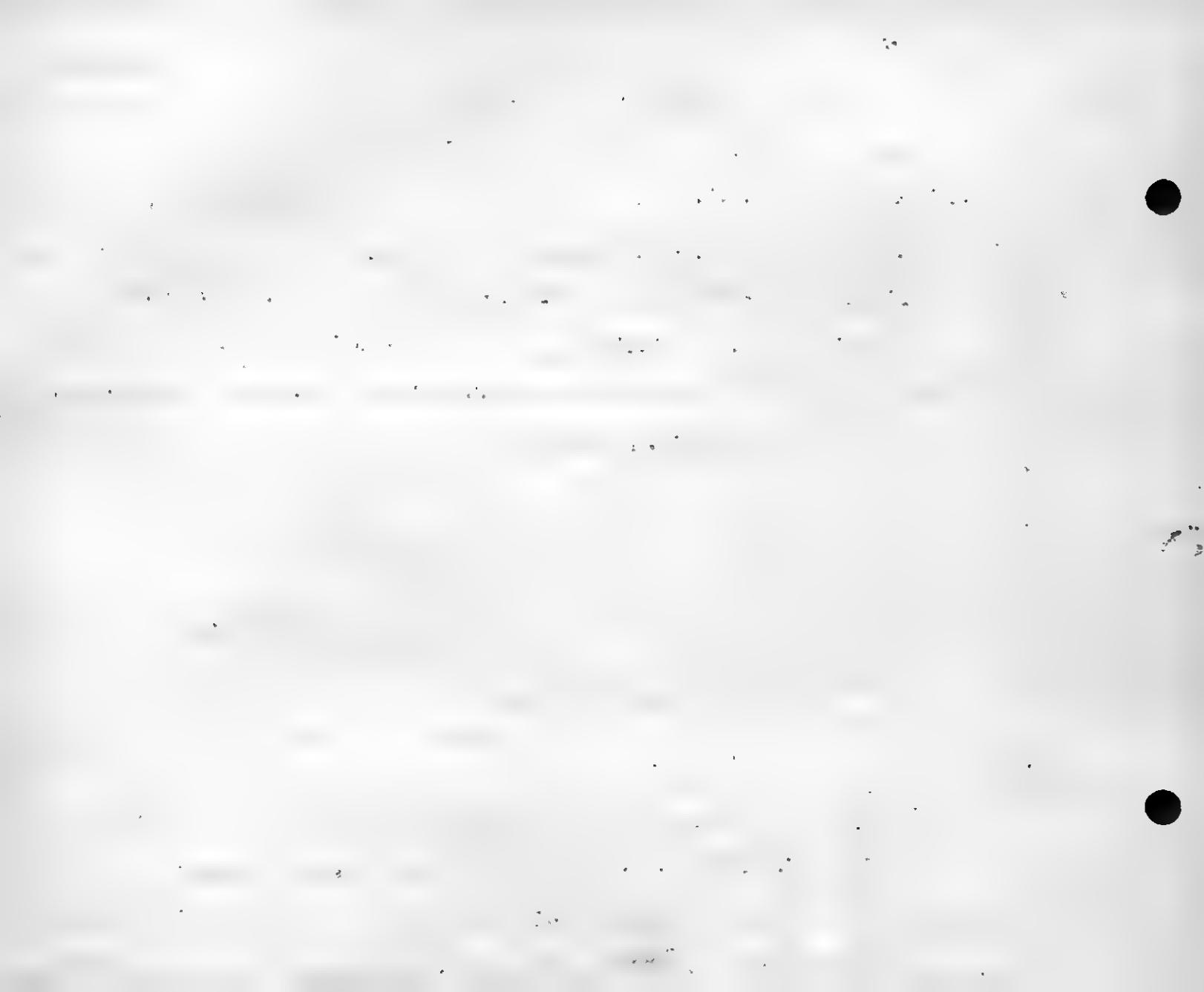
14180

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

SHIPPED TO: DAVISON FUNERAL HOME, LEXINGTON, NORTH CAROLINA

1 DECEASED NAME (Type or print)	First JOHN	Middle HAYDEN	Last WILSON	2a DATE OF DEATH Month 10 Day 15 Year 68	2b. HOUR 12:45PM		
3 SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 6/29/10		6. AGE (in years last birthday) 58 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (State or foreign) SOUTH CAROLINA	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE COUNTY, Md.				
10. CITY OR TOWN OF DEATH FORT HOWARD	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital or street address) VET. ADM. HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) GUARD		12b. KIND OF BUSINESS OR INDUSTRY DETECTIVE AGENCY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Resdence before admission) STATE MARYLAND	13b. COUNTY BALTIMORE	13c. CITY OR TOWN MIDDLE RIVER	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 15 W. Hickam Road			
14. FATHER'S NAME First JOHN	Middle C.	Last WILSON	15. MOTHER'S MAIDEN NAME First MINNIE	Middle L.	Last HAYDEN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES	16b. SOCIAL SECURITY NO (If yes give war or dates of service) WW II 241 01 74 20	17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.	Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS	
4017 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO AUTOPSY	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9/29/68 , 19, to 10/15/68 , 19, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10/15/68 , 19, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (did not) view the body after death.							
22b. SIGNATURE <i>Peter N. Juvan</i>		DEGREE ATTENDING PHYS	<input type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 10/15/68		
22d. PHYSICIAN'S NAME (Type) PETER N. JUVAN, M. D.		22e. ADDRESS VAH FORT HOWARD, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 10/19/68	23c. NAME OF CEMETERY OR CREMATORIUM LEXINGTON CITY CEMETERY	23d. LOCATION (City or Town) LEXINGTON, NORTH CAROLINA		(County)	(State)	
24. FUNERAL DIRECTOR <i>Joseph J. Zannino</i>	ADDRESS ZANNINO FUNERAL HOME	25a. REG'D BY REGISTRAR OCT 21 1968	25b. REG. STRR'S SIGNATURE <i>Charles Judge</i>				
VR A15 (4) 30M REV. 1/74							



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1-178

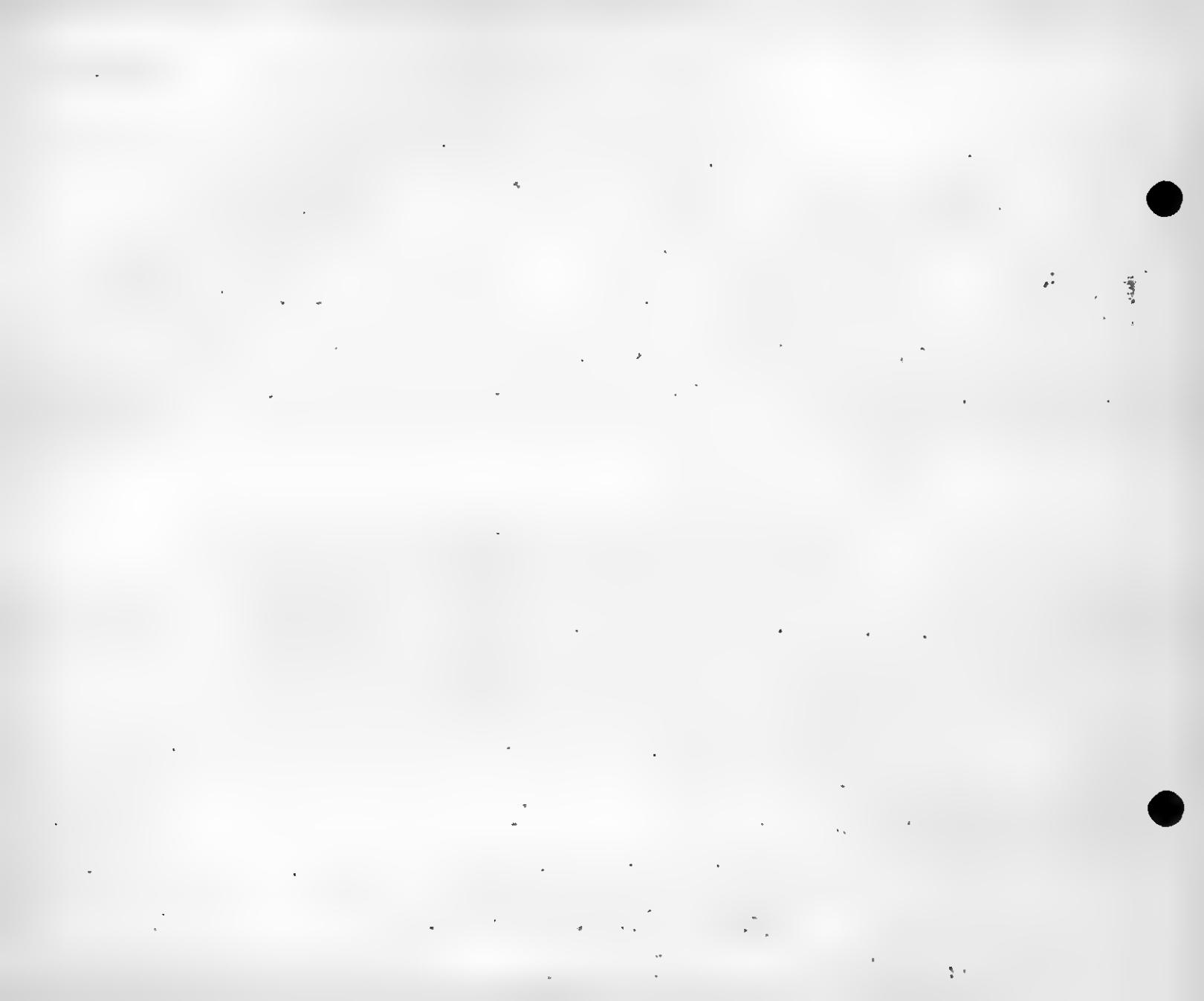
14181

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be ~~mailed~~ within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages one and two should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Page 4 may be retained by the hospital or attending physician.

1. DECEASED-NAME (Type or print)	First <i>Mary</i>	Middle <i>E.</i>	Last <i>Winkler</i>	2a. DATE OF DEATH Month <i>Oct</i>	Day <i>19</i>	Year <i>68</i>	2b. HOUR <i>7:15 PM</i>
3 SEX <i>Female</i>	4 RACE <i>White</i>	5 DATE OF BIRTH <i>Sept 1, 1890</i>		6 AGE (In years last birthday) <i>73 yrs.</i>		7 IF UNDER 1 YEAR MONTHS <i>0</i>	
7a. BIRTHPLACE (State or foreign country) <i>Newport News, Va</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Baltimore</i>		8 IF UNDER 24 HRS HOURS <i>0</i>	
10. CITY OR TOWN OF DEATH <i>Overlea</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>3911 Overlea Ave</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Maryland</i>	13b. COUNTY <i>Baltimore</i>	13c CITY OR TOWN <i>Overlea</i>	13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>3911 Overlea Ave.</i>			
14. FATHER'S NAME <i>Wolfgang</i>	First Middle <i>Schoenberger</i>	Last	15. MOTHER'S MAIDEN NAME <i>Margaret</i>	First Middle <i>Meyer</i>	Last		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b SOCIAL SECURITY NO. <i>212-01-24538</i>	17 INFORMANT <i>Herman R. Winkler</i>	Address <i>3911 Overlea Ave.</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 mth</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <i>Uterus</i>							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>1829</i>							
(b) <i>Adenocarcinoma of uterus with metastasis</i>							
DUE TO, OR AS A CONSEQUENCE OF							
(c) <i>metastasis</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)							
174							
19a DATE OF OPERATION <i>May 1968</i>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Adenocarcinoma uterus</i>		20a AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b TIME OF INJURY HOUR A.M. <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from <i>May</i> , 19 <i>68</i> , to <i>Oct</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Oct 16</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Charles M. Kerr MD</i>							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <i>6801 Belair Rd Baltimore Md.</i>	22c. DATE SIGNED <i>Oct 21, 68</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE <i>Oct 23, 1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Baltimore National Cemetery</i>		23d. LOCATION (City or Town) <i>Frederick Ave Belts. Md.</i>	(County)	(State)
24. FUNERAL DIRECTOR <i>Dippel Bros Inc. 7110 Belair Rd.</i>		ADDRESS	25a. REC'D BY REGISTRAR <i>DATE OCT 22 1968</i>		25b. REG STRR'S SIGNATURE <i>Charles Judge</i>		



1
1173

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Stephen	Middle Erick	Last WISE	2a. DATE OF DEATH Month 10 Day 5 Year 68	2b. HOUR 2:55 P.M.
3. SEX Male	4. RACE White	S. DATE OF BIRTH 3/28/66	6. AGE (In years last birthday) 2 yrs.	IF UNDER 24 HRS MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore		
10. CITY OR TOWN OF DEATH Owings Mills	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rosewood State Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Dependent	12b. KIND OF BUSINESS OR INDUSTRY none		
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Maryland	13c. CITY OR TOWN Prince George	13d. INSIDE CITY LIMIT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 5805 Old Temple Hill Road		
14. FATHER'S NAME Victor Henry Wise, Jr.	15. MOTHER'S MAIDEN NAME Betty Catherine Trail				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no	16b. SOCIAL SECURITY NO. ---	17. INFORMANT none	Rosewood Records, Owings Mills, Maryland	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory insufficiency, tuberculosis</i> APPROXIMATE INTERVAL DUE TO, OR AS A CONSEQUENCE OF <i>4 wks.</i> BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>50x</i>					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c) <i>Acute passive congestion & pulmonary edema moderate.</i>					
19a. MEDICAL CERTIFICATION DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from 6/22, 19 62, to 10/5, 19 68, that (we) last saw the deceased alive on 10/5, 19 68, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Richard A. Jones</i>	DEGREE	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED 10/7/68
22d. PHYSICIAN'S NAME (Type)	Richard A. Jones, M.D.		22e. ADDRESS Rosewood St. Hosp., Owings Mills, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Oct. 9, 1968	23c. NAME OF CEMETERY OR CREMATORIUM Rosewood Cemetery	23d. LOCATION (City or Town) Owings Mills, Md.	(County)	(State)
24. FUNERAL DIRECTOR J.F. Eline & Sons	ADDRESS Reisterstown, Md.	25a. REC'D BY REGISTRAR DATE OCT 11 1968	25b. REGISTRAR'S SIGNATURE <i>Charles J. Jones</i>		



16176

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

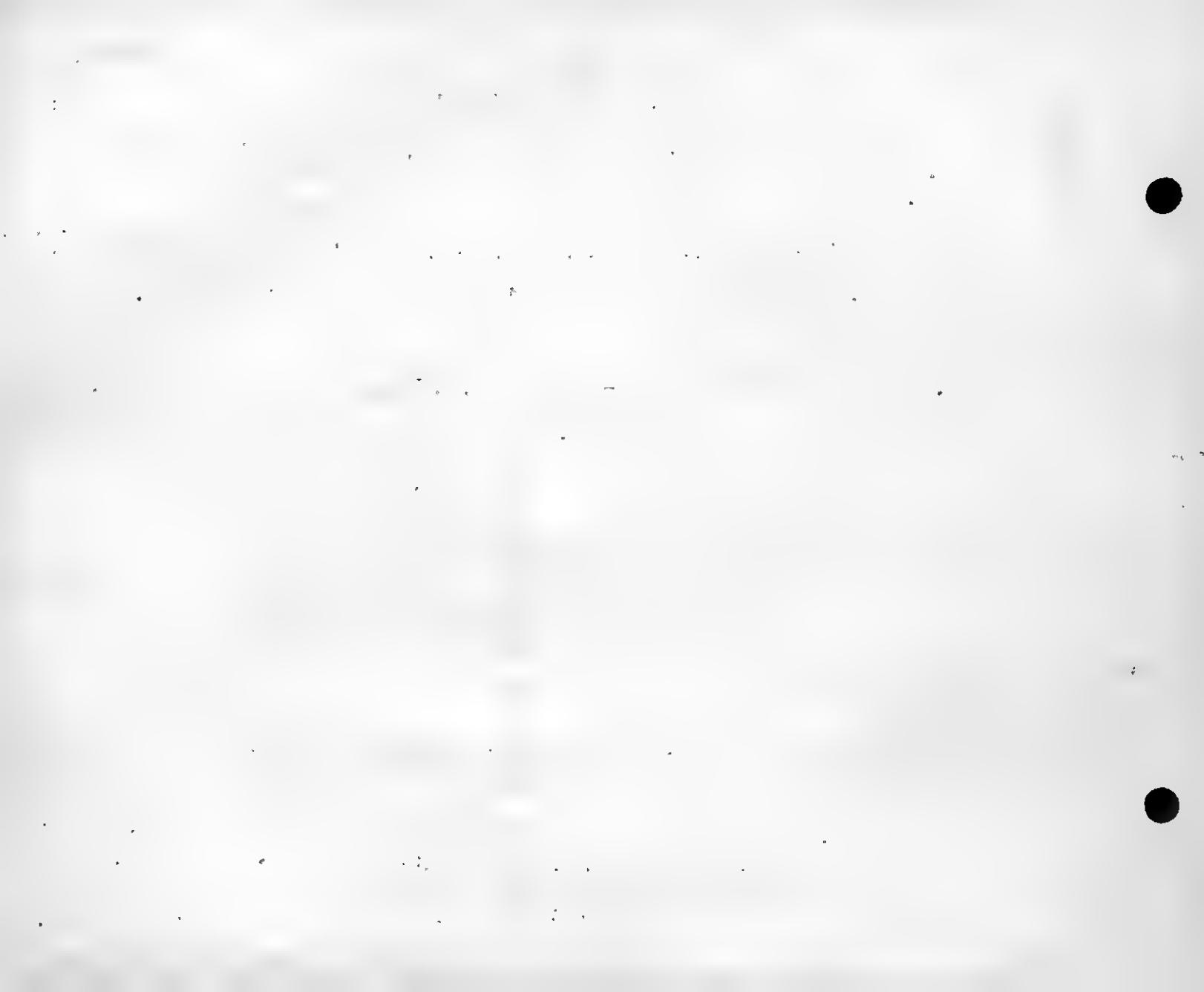
14183

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be countersigned within 24 hours after death.

Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 7 hours of her death.

1 DECEASED-NAME (Type or print)		First MARY	Middle F.	Last YINGLING	2a. DATE OF DEATH Month 10	Doy 30	Year 68	2b. HOUR P 11:50 M		
3 SEX Female		4 RACE Cau.	5 DATE OF BIRTH May 10, 1910		6. AGE (In years last birthday) 58		IF UNDER 1 YEAR MONTHS 5		F. UNDER 24 HRS. HOURS 1	
7a BIRTHPLACE (State or foreign country) Md.		7b CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore,					
10 CITY OR TOWN OF DEATH Baltimore, Md.		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Med. Cen.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Welder		12b. KIND OF BUSINESS OR INDUSTRY P.E.S. Span Catalyst				
13a. US/JAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMIT YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 721 W. 34th St.				
14. FATHER'S NAME First Walter		Middle B.	Last Shauck	15. MOTHER'S MAIDEN NAME First Catherine		Middle Kirwin	Last 			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO 212-07-5055		17. INFORMANT Chas. E. Yingling - 721 W. 34th St.		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis										
4107		DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic Cardiovascular Disease								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF 						
		(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
4107		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			Yes	
MEDICAL CERTIFICATION		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. 10 Month Oct. Day 30 Year 68	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) While at work						
		21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State		
22a. I certify that (I) (this hospital) attended the deceased from Oct. 30, 19 68, to Oct. 30, 19 68, that (I) (we) lost saw the deceased alive on Oct. 30 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Charles C. Brown, M.D.</i>		DEGREE Charles C. Brown, M.D.	ATTENDING PHYS. <input type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED Oct. 31, 1968				
22d. PHYSICIAN'S NAME (Type) Charles C. Brown, M.D.		22e. ADDRESS Greater Baltimore Medical Center								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/4/68	23c. NAME OF CEMETERY OR CREMATORIAL Meadowridge Cem.		23d. LOCATION (City or Town) Howard County,		(County) 	(State) Md.		
24. FUNERAL DIRECTOR Austin E. Donovan - 3818 Roland Ave.		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE NOV 4 1968 Charles Judge				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14175
10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Please sign and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First William	Middle T.	Last Young	2a. DATE OF DEATH Month 10	Day 9	Year 68	2b. HOUR 8 P. M.
3. SEX male		4. RACE white		S. DATE OF BIRTH 9-13-1899	6. AGE (in years last birthday) 69 YRS.		IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 523 N. Potomac St.		
14. FATHER'S NAME First George		Middle W.	Last Young	15. MOTHER'S MAIDEN NAME First Emma		Middle M.	Address	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. (If you give war or dates of service) 218-09-8760		17. INFORMANT Mrs. Mary Young		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive acute myocardial infarction</p> <p>4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p> <p>(b) DUE TO, OR AS A CONSEQUENCE OF (c)</p> <p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p> <p>4201</p>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9-29 , 19 68 , to 10-9 , 19 68 , that 10 (we) last saw the deceased alive on 10-9 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Ines Cilliani</i>		DEGREE ATTENDING PHYS.	<input type="checkbox"/>	MED. DIRECTOR	<input type="checkbox"/>	STAFF PHYS.	<input checked="" type="checkbox"/>	22c. DATE SIGNED 10/10/68
22d. PHYSICIAN'S NAME (Type) Ines Cilliani, M.D.		22e. ADDRESS 7620 York Road, Baltimore, Md. 21204						
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 10-11-68	23c. NAME OF CEMETERY OR CREMATORIAL Western Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore City Maryland			
24. FUNERAL DIRECTOR		ADDRESS Couch Funeral Homes 1211 Chesaco Ave.		25a. REC'D BY REGISTRAR DATE OCT 14 1968		25b. REGISTRAR'S SIGNATURE <i>Judge</i>		

48101

48101

48101

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First CHARLES	Middle A.	Last ZANG	20. DATE OF DEATH Month October	Day 19	Year 1968	26. HOUR 8 P.M.	
3. SEX MALE		4. RACE WHITE		S. DATE OF BIRTH June 13, 1912.	6. AGE (In years last birthday) 56		IF UNDER 1 YEAR MONTHS 0		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore, Md.		IF UNDER 24 HRS. HOURS 0		
10. CITY OR TOWN OF DEATH Parkville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2002 Summit Avenue		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Steam Engineer		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES	13e. STREET AND NUMBER 2802 Summit Avenue			
14. FATHER'S NAME First Alfred		Middle J.	Last Zang	15. MOTHER'S MAIDEN NAME First Minnie		Middle Edelman	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 213-10-9208		17. INFORMANT Mrs. Dorothy Zang		Address (Same)			
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Mesothelioma - Collagenosis</i></p> <p>228X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b)</p> <p>DUE TO, OR AS A CONSEQUENCE OF (c)</p> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mo</p>									
<p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p> <p>229X</p>									
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State	
<p>22a. I certify that (I) (this hospital) attended the deceased from Jan 1, 1968, to Oct 19, 1968, that (I) (we) lost saw the deceased alive on Oct 19, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</p>									
22b. SIGNATURE <i>C. Herbert Mueller Jr</i>		DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 10/21/68			
22d. PHYSICIAN'S NAME (Type) C. HERBERT MUELLER JR		22e. ADDRESS Parkton Med.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/23/68.		23c. NAME OF CEMETERY OR CREMATORIAL Oaklawn Cemetery		23d. LOCATION (City or Town) Baltimore, Md.		(County) (State)	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		ADDRESS		25a. RECORD BY REGISTRAR OCT 21 1968		25b. REGISTRAR'S SIGNATURE <i>James Judge</i>			
				DATE					

28145

F. 1000000

0500

A

Z-100

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

Yesterdays

disis.

1000

1000